Section 1915(b) Waiver
Proposal for State of Rhode Island Prepaid Ambulatory Health Plan (PAHP) for Dental Benefit Management (DBM)

September 29, 2005
Draft

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Face Sheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of **Rhode Island** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **for a Dental Benefit Management program called Bright Smiles**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

_X_ initial request for new waiver. All sections are filled.

___ amendment request for existing waiver, which modifies Section/Part ____

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

___ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is ___ replaced in full

___ Carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective **January 1, 2006** and ending **December 31, 2007**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is **Tricia Leddy** and can be reached by telephone at (**401**) **462-2127**, or fax at (**401**) **462-6353**, or e-mail at **TriciaL@dhs.ri.gov**. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Representatives of the Rhode Island Department of Human Services (DHS) met with representatives of the Narragansett Tribe and provided them with an opportunity to comment on the waiver proposal. The tribal representatives support the proposal as written.

Program History
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Dental Coverage under Rhode Island Medicaid

Dental services are covered in Rhode Island under the Medicaid fee-for-service (FFS) system. For those enrolled in RIte Care, the State's Medicaid managed care program, this means that dental services are an out-of-plan benefit. The sole exception pertains to dental emergencies for which RIte Care-participating Health Plans are responsible. Specifically, Section 1.11 of the *RIte Care Health Plan Contract*, effective January 1, 2005, defines an Emergency Dental Condition as follows:

> **"**Emergency Dental Condition means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, eliminate acute infection, pulpal death, or loss of teeth."

For those enrolled in RIte Share, the State's premium assistance program, dental services including emergencies are covered as a Medicaid wraparound benefit under the Medicaid FFS system.

Coverage of dental services in Rhode Island Medicaid is guided by the *Dental Services Coverage Policy*, which is included in this proposal as Attachment A. The attachment shows on a procedure-by-procedure basis what is covered under the policy and clearly delineates any limitations such as applicable age restrictions or prior authorization requirements. With respect to age restrictions, it should be noted that adults have limited coverage for dental benefits compared to children under age 21.

Issues with Access to Dental Services for Rhode Island Child Beneficiaries

Like all other States, Rhode Island is required to report annually to the Centers for Medicare & Medicaid Services (CMS) on the State's Medicaid-eligible children's participation in EPSDT. The Rhode Island Medicaid program calculates the following key ratios in order to report to CMS on the CMS-416:

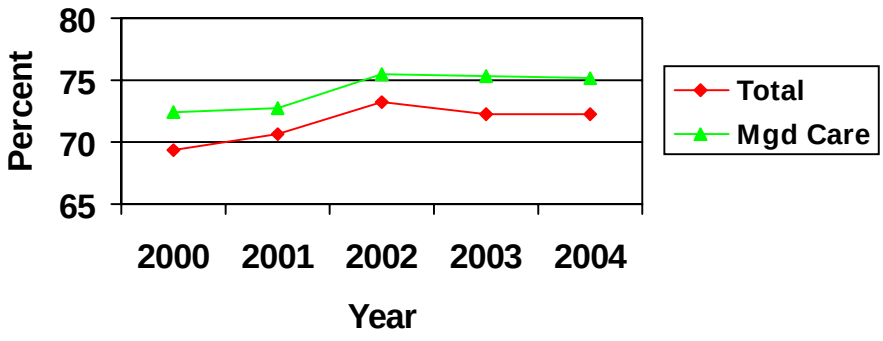
- **Participation Ratio** – The proportion of EPSDT eligibles who should receive at least one initial or periodic screen who actually receive them

- **Screening Ratio** – The extent to which EPSDT eligibles receive the number of initial and periodic screening services, adjusted by the portion of the year for which they are eligible

These ratios are calculated for all EPSDT eligibles as well as separately for those EPSDT eligibles enrolled in managed care (i.e., RIte Care). As Figure 1 shows, the EPSDT Participation Ratio for all EPSDT eligibles has leveled off at about 72 percent over the past two Federal fiscal years while the ratio for EPSDT eligibles enrolled in RIte Care has leveled off at approximately 75 percent.

Figure 1

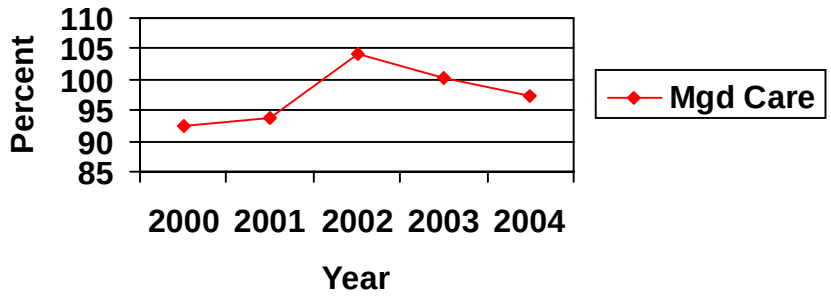
Rhode Island Medicaid EPSDT Participation Ratio for EPSDT Eligilbes Who Are 5 Years of Age or Less: FFY 2000-2004



As Figure 2 shows, the Screening Ratio for EPSDT eligibles enrolled in RIte Care has ranged between 94 and 104 percent over the past five Federal fiscal years. This ratio can sometimes exceed 100 percent because some children receive more services that the Rhode Island EPSDT Periodicity Schedule indicates. This could be a child with a chronic condition, for example.

Figure 2

Rhode Island Medicaid EPSDT Screening Ratio for ESPDT Eligibles Who Are 5 Years of Age or Less: FFY 2000-2004



While overall EPSDT participation and screening ratios are generally at acceptable levels, this is not the case with dental screenings. The Rhode Island EPSDT Periodicity Schedule stipulates: "All children age three and older must be referred directly to a dentist for screening annually as part of an EPSDT exam." Therefore, dental screenings are supposed to occur at ages 3, 4, and 5. In addition, children younger than three may also receive screenings or other dental services.[1]

As Table 1 shows, the percent of Rhode Island Medicaid-eligible children who were 5 years of age or less who were eligible to receive an EPSDT screen who received a dental service has declined progressively over the past five Federal fiscal years – from 18.3 percent in FFY 2000 to 15.2 percent in FFY 2004. These percentages are less than the comparable nationwide 1996 – 2000 benchmark[2] for children less than 6 years of age – 21 percent. It should be noted that these data are not partitioned by whether they are enrolled in managed care, unlike the overall EPSDT screening ratios, because, as specified above, dental services are provided in Rhode Island under the Medicaid FFS system.

[1] It should be noted the State's EPSDT Periodicity Schedule is within CMS guidance. See: Centers for Medicare & Medicaid Services. *Guide to Children's Dental Care in Medicaid*, October 2004.
[2] Brown, E. and R. Manski. *Dental Services: Use, Expenses, and Sources of Payment: 1996 – 2000.* Agency for Healthcare Research and Quality, MEPS Research Findings No. 20, AHRQ Pub. No. 04-0018, 2004.

Table 1

Percent of Rhode Island Medicaid-Eligible Children Who Were 5 Years of Age or Less Who Were Eligible to Receive an EPSDT Screen Who Received a Dental Service: FFY 2000 - 2004

	FFY 2000	FFY 2001	FY 2002	FY 2003	FY 2004
Total Eligible to Receive an EPSDT Screen	30,737	32,520	34,318	34,824	35,249
Total Who Received Any Dental Service	5,628	5,660	5,585	5,545	5,374
Percent of Eligibles Who Received a Dental Service	18.3%	17.4%	16.3%	15.9%	15.2%

It should be noted that Rhode Island's percentages are improved when viewing the entire children's Medicaid population (i.e., under 21), as the data in Table 2 show[3]:

Table 2

Percent of EPSDT-Eligible Children Who Were 21 Years of Age or Less Who Received Any Dental Service

State	Percent with Any Dental Service
Connecticut	33%
Delaware	24%
Massachusetts	33%
Michigan	30%
New Jersey	22%
New York	24%
Pennsylvania	28%
Rhode Island	**34%**
Vermont	47%

[3] American Dental Association. *State Innovations to Improve Oral Health Care for Low Income Children: A Compendium Update*, 2005.

Children's unmet need for dental care has also been documented in Rhode Island from a number of studies. For example, three Rhode Island-based surveys – Children with Disabilities Survey[4], RIte Care Family Survey[5], and Foster Children Survey[6] – have demonstrated this need:

- Among children with disabilities on FFS Medicaid in 1998, dental care ranked 6th out of the 28 most unmet health care services need.

- Among children in RIte Care who had continuous health coverage in 2003, dental care ranked 1st out of 8 as the most unmet health care services need. Among children with intermittent coverage, dental care also ranked 1st.

- Among foster children in RIte Care in 2004, dental care ranked 1st out of 5 as the most unmet health care services need.

Annual RIte Care Member Satisfaction Surveys have also confirmed the need for greater access to dental services for children.

Private dental practitioner participation in Medicaid in Rhode Island has been historically low. Of the currently practicing dentists licensed in the State of Rhode Island, 51 percent have made claims to Medicaid in the past two State fiscal years. Low provider participation outside of a managed care environment in Medicaid is not new in Rhode Island. When RIte Care began, less than 40 percent of the practicing physicians licensed in the State participated in Medicaid. Under RIte Care's managed care environment, more than 90 percent participate.

Feedback from the Rhode Island Dental Society has indicated repeatedly that Medicaid payment rates play the critical role in the low participation levels. As will be shown in Section C. of this proposal, it is estimated that Medicaid payments rates for dental services in Rhode Island is 41 percent of the commercial payment rate in the State. It should be noted that Medicaid payment rates in the State have been unchanged for 12 years.

A Brief History of Developments in Rhode Island to Address Medicaid Dental Access Issues

In the fall of 1998, DHS established the Medicaid Dental Advisory Committee (MDAC) with the purpose of developing recommendations for improving access to dental services for individuals covered by the Rhode Island Medicaid, including children and families enrolled in RIte Care and uninsured working families. The committee included

[4] Griffin J. *Health Care Needs of Children with Disabilities on Medicaid: Results of A Caregiver Survey*, MCH Evaluation, Inc., June 1998.
[5] Payne, C. *Rhode Island Children and Adolescents in Foster Care: A comparison of Relative and Non-Relative Foster Care Arrangements*, MCH Evaluation, Inc., 2004.
[6] Griffin, J. *Do Gaps in Children's Health Insurance Make a Difference? Results from the RIte Care Family Health Survey*, RI Medicaid Research and Evaluation Project, September 2004.

representatives of the Rhode Island Dental Society, Samuels Dental Center, St. Joseph Hospital Dental Program, the Rhode Island Health Center Association, Kids Count, the Rhode Island Foundation, the Rhode Island Dental Hygienist Association, Travelers Aid Society, the Rhode Island HMO Association, two Rhode Island-based dental benefit managers, private practice dentists, other State agencies, and consumer advocacy groups.

In 1999, MDAC recommended that DHS develop purchasing specifications for a Dental Benefit Manager (DBM). The DBM program was expected to be implemented as an alternative to the fee-for-service (FFS) dental system for all Medicaid program enrollees, with implementation on an incremental basis beginning with children and families, and enrolling adults with disabilities and the elderly institutions at a later date. Later that year, DHS developed a Request for Proposals (RFP) soliciting a qualified organization to serve as DBM for Rhode Island Medicaid recipients through a program called *RIte Smiles*. Unfortunately, in 2000, unanticipated growth in RIte Care enrollment diverted the state's focus to containing the overall Medicaid budget, and the solicitation process was put on hold. However, DHS moved ahead to implement many of the committee's recommendations within the current Medicaid dental FFS system. In an effort to expand participation of dentists in Medicaid, Medicaid restructured its dental fee schedule several years earlier using the recommendations of the Rhode Island Dental Society. However, timely payment issues and complex/outdated and long prior approval procedures continued to plague the dentists. Enrollee transportation issues further exacerbated the high missed appointment problem. DHS acted to resolve these issues with the following results:

- Dental claim payments are now made within an average of 18 days.
- DHS drastically reduced the number of procedures requiring prior approval, including dentures, crowns, bite wings, and several single restorations.
- DHS updated prior approval requirements by allowing submission of x-rays rather than molds.
- DHS streamlined the prior authorization process resulting in a reduced turnaround time on remaining dental prior approvals to within 17 days, which is consistent with the commercial insurance community.
- DHS completed a standard pricing survey of the local dental community, and as a result, established a consistent pricing schedule.
- DHS established a Transportation Hotline for recipients without transportation.

Providence Smiles. In 1999, a school-based dental sealant program, funded by the Robert Wood Johnson Foundation, the DHS, HELP (the Health Education and Leadership for Providence Coalition) and the Rhode Island Foundation, called Providence Smiles was launched in ten Providence middle schools. The program, administered by St. Joseph

Hospital in Providence provides dental examinations, cleanings, fluoride treatment, sealants, simple restorations, community outreach, education, and referrals for more extensive treatment. The program has been replicated in the city of Pawtucket. The program has had a significant impact on improving access to dental care for children enrolled in Medicaid.

*Rhode Island Senate Oral Health Commission***.** In 2000, a *Special Senate Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents* (Senate Oral Health Commission) was created by the Rhode Island General Assembly. The Commission is led by Senator Elizabeth Roberts, recognized for her expertise and advocacy in the health care and health policy arenas, and the membership includes representatives of social service agencies, state agencies, professional associations, community health centers, the dental professional community, safety net providers, and the Rhode Island Foundation.

In November 2001, the Commission issued its report and recommendations. As a result of the Commission's efforts, two legislative grants totaling $300,000 were awarded to the two Rhode Island hospital-based clinics: St. Joseph Hospital and Samuels Dental Clinic in FY 2002. The focus of these grants is to encourage these clinics to expand dental access by buying new equipment, hiring new staff, and expanding clinic hours. Both of these clinics serve over 90 percent Medicaid patients and have been successful in helping to increase the number and percentage of Medicaid enrolled children who accessed dental services in Fiscal Year (FY) 2001 and FY 2002.

Rhode Island KIDS COUNT Policy Briefing. In 2000, Rhode Island KIDS COUNT, a children's policy and advocacy organization, published a comprehensive resource, data and policy report titled "Access to Dental Care For Children in Rhode Island." The report concluded with eight recommendations, including: (1) explore the potential for a Dental Benefits Manager as a strategy to reduce barriers to care and increase accountability for providing the comprehensive dental prevention and treatment services required under federal Medicaid law; (2) maintain and strengthen the dental services infrastructure at community health centers across the state; and (3) form a public-private partnership to create a blueprint to expand access to dental services for low-income children in Rhode Island. Rhode Island KIDS COUNT updated the Oral Health Issue Brief in October 2004.

Rhode Island Oral Health Access Project. Rhode Island was one of only six States to receive a State Action for Oral Health grant award from the Robert Wood Johnson Foundation. Rhode Island will receive $ 940,000 over a 3-year period (from December 2002 to November 2005).

The goals of this project are to: (1) restructure the Medicaid dental benefit to improve access to dental care with an emphasis on preventive and primary dental care; (2) increase the capacity of dental "safety net" providers in the state and expand Providence Smiles; the successful school-based prevention program, to additional school districts,

and (3) increase the supply of pediatric dentists, dental hygienists, and dental assistants in the State.
The Rhode Island Oral Health Access Project will transition Medicaid from a payer to a purchaser for dental services and will expand dental capacity in underserved areas to Medicaid enrolled children and families. The first component of the project is to develop and implement a dental benefit management program, which will be offered in place of the current Medicaid FFS dental benefits, and will cover primary and preventive dental services Statewide for all children and families enrolled in Medicaid. The second part of the Project will expand dental service capacity in underserved areas by implementing activities which will broaden the Medicaid provider network, expand the dental safety net, expand the state's childhood dental sealant program and educate consumers and providers. These activities will implement the recommendations of the Rhode Island Senate Oral Health Commission, which developed these specific recommendations over a one-year period.

DHS' partners in implementing this grant are Rhode Island Kids Count and the Rhode Island Foundation.

The following chronicles the activities for the Dental Benefits Manager (DBM) objective of the project since December 2004. The DBM Project has clearly made tremendous strides toward implementation. The DHS staff and consultants have completed the following tasks:

- Completed work around the July 1, 2005 implementation of a new standardized orthodontic case review criterion. It is estimated that the use of the new criteria will save approximately 25 percent of the annual expenditures for Medicaid dental.

- Designed a tracking system with performance measures to monitor the new prior authorization process, the inter-rater reliability as well as the cost savings (outcomes) realized by implementing the new criteria.

- Convened two benefit subgroup meetings in January 2005 to review current service coverage, benefit design options, and to make recommendations to the State for cost-savings modifications if applicable.

- Completed an intensive analysis with Mercer Human Resources, Inc., the actuarial firm hired to price options that have been developed, and to evaluate/project the anticipated impact on utilization, provider enrollment, and expenditure trends.

- Formed an internal DBM Strategies Workgroup that continues to meet weekly to make recommendations/decisions about Project-related issues around key issues like systems integration, contracting/procurement, communications, and quality review standards.

- Prepared a draft DBM Terms and Conditions document for Workgroup review.

- Assigned smaller internal task groups to work concurrently with the larger internal DBM Strategies Workgroup to ensure the most productive internal taskforce possible for the DBM initiative.

- Convened several individual meetings with local Health Plans to discuss the Project's provisional direction and to gather feedback from each as the Project moves forward.

Overview of Rhode Island's Section 1915(b) Proposal

This Section 1915(b) Waiver Proposal is a direct outgrowth of the foregoing activities. Specifically, Rhode Island seeks to build upon its managed care success with the Section 1115 waiver for RIte Care and RIte Share and proposes to contract with Dental Benefit Managers (DBMs) on behalf of Medicaid-eligible children born on or after January 1, 2000 enrolled in RIte Care, RIte Share, and Medicaid FFS to:

- Improve access to dental care for these children

- Increase the percentage of these children who receive dental services

- Shift, over time, the types of dental services these children receive to more preventive care

- Shift, over time, the types of providers of dental services to more private practicing dentists

Children under age six have been selected as the target population for this project to conform to the level of State appropriations provided by the Rhode Island General Assembly to be used for the Federal match. As such, this is a beginning point for what will hopefully be future expansions, over time, to children up to age 21 as additional State funds are appropriated for this purpose. This incremental approach to population expansion is consistent with the population expansions under RIte Care described earlier.

As Section D of this Waiver Proposal shows, the State expects an increase in the utilization of dental services by the target population. The State also expects that the unit costs for dental services will increase as the DBMs increase provider rates in order to expand access of the target population to private practicing dentists. Therefore, the State expects overall costs to increase initially under this demonstration project. However, over time, the State expects these cost increases to moderate as care is shifted from treatment services to preventive services and to more private practicing dentists.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. **_X_ 1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. **___ 1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. **___ 1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. **_X_ 1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards, which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

___ MCO
___ PIHP
_X_ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a.___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b._**X**_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c._**X**_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d._**X**_ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

The State is seeking this waiver authority even though the State will make a concerted effort to have at least two DBMs that are PAHPs in order for beneficiaries to have a choice of PAHPs. Please see B.2 and C.1 below in this regard.

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.___ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

___ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c._**X**_ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

_**X**_ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

_X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

The State of Rhode Island intends to use a Bid Specifications Document.

_X_ **Open** cooperative procurement process (in which any qualifying contractor may participate)

The State of Rhode Island intends to contract with two or more qualified PAHPs (according to the Bid Specifications Document criteria) in sufficient numbers to meet the needs to the eligible population under this waiver.

___ **Sole source** procurement
___ **Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

__ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

_**X**_ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

Although the State of Rhode Island intends to contract with at least two PAHPs to provide dental benefit management services in order for beneficiaries to have a choice of more than one PAHP, the State cannot assure CMS at this time that there will be at least two such entities that qualify under the State's projected bidding process and successfully negotiate contracts with the State. Therefore, the State seeks a waiver of section 1902(a)(4) in the event that only one PAHP is successfully contracted under the State's bidding process. Whether the State has only one PAHP or more than, the State's expects access to dental providers will be the same as or exceed the access under the FFS system.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
__ Two or more PIHPs.
_**X**_ Two or more PAHPs.
___ Other: (please describe)

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

_X_ **Statewide** -- all counties, zip codes, or regions of the State

___ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

The State will only contract with PAHPs that are willing to serve the entire State, identical to the basis on which the State contracts with MCOs under its Section 1115 waiver for RIte Care.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	**PAHP**	**To be determined through formal bidding process, as described in B.2. above**

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

   This waiver will only be for Medicaid-eligible children born on or after January 1, 2000.

   _X_ Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

   _X_ Mandatory enrollment
   ___ Voluntary enrollment

   ___ Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   ___ Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   _X_ Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

   _X_ Mandatory enrollment
   ___ Voluntary enrollment

   ___ Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

_X_ Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

_X_ Mandatory enrollment
___ Voluntary enrollment

___ TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

This waiver will not be applicable to SCHIP, as Rhode Island's SCHIP State Plan applies only to children between 8 and their 19th birthday.

___ Mandatory enrollment
___ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

___ Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

___ Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

_X_ Other Insurance--Medicaid beneficiaries who have other health insurance.

Those children with third-party coverage for dental benefits will be excluded from this waiver.

_X_ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

___ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

___ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

___ **Other** (Please define):

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

_X_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

The State of Rhode Island seeks a waiver of 1902(a)(4) for comparability under 42 CFR 438.210(A)(2) , because of the expected network differences between the DBM and FFS Medicaid (e.g., certain dental specialists in the State do not participate in FFS Medicaid but are expected to participate in the DBM).

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-

(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X_ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):

_X_ Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

_**X**_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM, which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

PAHPs will be required to contract with FQHCs that provide dental services.

___The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

_**X**_The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

___This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

_**X**_The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

For Dental Services:

Prior Authorization (PA) requirements for dental services under this waiver will remain as required under the current Medicaid FFS system. Each dental service requiring prior authorization is detailed using

American Dental Association nomenclature in the *Dental Services Coverage* Policy, which is incorporated into this waiver proposal as Attachment A.

For Dental Specialists:

No formal Prior Authorization (PA) will be required for a beneficiary who is enrolled in a DBM program to be treated by a dental specialist. This includes, but is not limited, to oral surgeons, endodontists, periodontists, pediatric dentists, orthodontists, and prosthodontists.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

B. Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

C. Coordination and Continuity of Care Standards

1. **Assurances For MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. **_X_ Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

The State's monthly enrollment report identifies children with special health care needs, which will be provided to the contracted DBMs. In Rhode Island, as noted in Section A., Part I, children with special health care needs are defined as:

- **Blind/disabled individuals up to age 21 eligible for Medical Assistance on the basis of SSI**

- **Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children) up to age 18**

- **Individuals up to age 21 receiving subsidized adoption assistance**

c. **_X_ Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

Upon notification that a child with special health care needs will be enrolled, the cognizant DBM will complete a welcome call or a direct contact with the child's family, guardian, or adult caregiver. In addition, the cognizant DBM will conduct an initial dental health screen for all children with special needs to identify any immediate service delivery or care coordination needs.

d. **_X_ Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3._**X** In accord with any applicable State quality assurance and utilization review standards.

If an unmet need or other dental health issue is identified during the initial dental health screen, the cognizant DBM's staff will work with the parent or guardian to develop a follow-up treatment plan. Treatment plans will be evaluated and updated every six months. In addition, contracted DBMs will be required to assure that network providers serving children with special health care needs do so according to guidelines set forth by the U.S. Department of Health and Human Services in *An Introduction to Practical Oral Care for People with Developmental Disabilities*.

e. **_X_ Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

As noted in F.7 above, all enrollees in the DBM will have direct access to specialty dentists. Enrollees will not need to seek referrals in order to see a dental specialist.

Section A: Program Description

Part III: Quality

1. **Assurances For PAHP program.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

a. **Scope of Marketing**

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2.**_X_** The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

The DBM: (1) shall not distribute marketing materials to less than the entire service area; (2) shall not distribute marketing materials

without the approval of DHS in consultation with the Medical Care Advisory Committee; (3) will not seek to influence enrollment in the DBM in conjunction with the sale or offering of private insurance; and (4) will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities. Beyond these prohibitions, the DBMs may advertise in print or other media so long as the advertising complies with 42 CFR 438.104(b)(2).

Advertising

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1._**X**_ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3._**X**_ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii._**X**_ Other (please explain):

If DBM has more than fifty (50) enrollees who speak a single language other than English as a primary language, the DBM agrees to make available general written materials in that language. The DBM must agree to be responsible for a true translation of materials prior-approved in English by the State,

subject to State oversight. All translated materials will be forwarded by the DBM to applicable enrollees.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as:
(check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3._**X**_ Other (please explain):

If DBM has more than fifty (50) enrollees who speak a single language other than English as a primary language, the DBM agrees to make available general written materials in that

language. The DBM must agree to be responsible for a true translation of materials prior-approved in English by the State, subject to State oversight. All translated materials will be forwarded by the DBM to applicable enrollees.

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

___ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X__ State
_X__ contractor (please specify) _____

Contracted DBMs will provide the State with information on the DBM (e.g., provider network) that can be provided to potential enrollees, similar to what is provided to potential enrollees in RIte Care. All such DBM-developed materials must be prior approved by the State.

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) **_X_** the State
(ii) **___** State contractor (please specify):_____
(ii) **_X_** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

DHS has developed a communications plan, which is included in this Waiver Proposal as Attachment B, to educate various external audiences concerning the DBM enrollment processes. These audiences include current Medicaid dental providers (including FQHCs and hospital-based dental clinics), pediatricians, current RIte Care members, parents of children with special needs, and the advocacy community.

This outreach process began with the inception of the DBM program by convening a workgroup of external stakeholders. This workgroup has met several times over the past 18 months and includes dental providers, FQHCs, RIte Care Health Plans, and advocates. DHS will meet with potential

vendors individually in the summer of 2005 to explain the planned implementation of the DBM.

Additionally, education of DBM-eligible Medicaid beneficiaries will occur through both the distribution of printed outreach materials and public forums.

b. **Administration of Enrollment Process**.

_X_ State staff conducts the enrollment process.

___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

___ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: _____

Please list the functions that the contractor will perform:

___ choice counseling
___ enrollment
___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

_X_ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

When implementation begins, the State intends to enroll all of the then DBM-eligible children into a DBM during the first month of the waiver project.

Since the State has not yet contracted with any DBM, it may be necessary, however, to phase in enrollment over a several-month period to accommodate, for example, individual DBM readiness to enroll eligible children and in what amounts, or other exigencies. Should it be necessary to conduct a phased-in enrollment, the State anticipates that this may be done by geographic area similar to how it phased in enrollment into RIte Care Health Plans for children with special health care needs or by population group (e.g., those enrolled

in RIte Care, first; those enrolled in RIte Share, second; and those in fee-for-service, third). An alternative may involve phasing-in by DBM. For example, it may be that through the DBM procurement process each of the three RIte Care-participating Health Plans may have a DBM affiliated with it (as a delegated subcontractor). It is conceivable that two of the DBMs may be ready to enroll eligible children on Day 1 but that the third may not be. In order to not disadvantage the third DBM, a possible approach is to designate those DBM-eligibles enrolled in the RIte Care Health Plan with which that DBM is affiliated the last group to be enrolled in a DBM. That way, beneficiaries would have a choice of that DBM, or any of the others, in which to enroll.

In the Implementation Plan included with this Waiver Proposal as Attachment C, it is assumed that enrollment of all then DBM-eligible children will be during the first month of implementation.

The State recognizes that there are compromises with any phased-in enrollment approach (e.g., some beneficiaries having a choice of only two DBMs versus others having a choice of three DBMs under the above alternative scenario). Ideally, the State will not have to undertake any phase-in enrollment, but the State must also be pragmatic at this time until the negotiations with potential DBM contractors take place through the procurement process. The goal in any event will be to enroll all DBM-eligible children into a DBM as smoothly and expeditiously as possible. It should be noted, however, that the State will not sacrifice the integrity of the enrollment process in terms of beneficiaries having sufficient information to make reasoned choices in order to expedite the number of children enrolled.

All DBM-eligible new Medicaid applicants will be enrolled on an ongoing basis from the first day of implementation.

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

_X_ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. **_X_** Potential enrollees will have **14** days/month(s) to choose a plan.
ii. **_X_** Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special

health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

Those DBM-eligible member families who neglect to indicate their choice of DBM within the 14-day time period will be auto-assigned in sequential order (i.e., DBM A, then, DBM B, etc.). RIte Care members will be default auto-assigned to a DBM affiliated with their Health Plan, if any. FFS Medicaid beneficiaries who do not make a DBM choice, RIte Share enrollees, and RIte Care families in a Health Plan that does not have an affiliated DBM contracting with the State, will be assigned in sequential order to one of the participating DBMs.

_X_ The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

_X_ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

Should, as a result of the DBM procurement process, there only be one DBM available, then all DBM-eligible beneficiaries will be automatically enrolled in that DBM. Otherwise, eligible beneficiaries will be auto-assigned as described above.

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

_X_ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Members who lose eligibility and re-enroll within 90 days will be assigned to the DBM they were a member of during their previous eligibility segment. If a member regains eligibility more than 90 days after the latest DBM enrollment in their family unit will be treated as

new members (i.e., they will be able to select the same or a different DBM via the MA application).

d. **Disenrollment:**

___ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i.___ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

_X_ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of **12** months (up to 12 months permitted), **or the next open enrollment period**. If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

Following 90 days after their initial enrollment into a DBM, enrollees shall be restricted to that DBM until the next open enrollment period, unless disenrolled under one of the conditions described below:

- **Loss of Medicaid eligibility including for non-payment of applicable premium shares for RIte Care or RIte Share**
- **Selection of another DBM during open enrollment**
- **Death**
- **Relocation out-of-State**
- **Adjudicative actions**
- **Change of eligibility status**
- **Eligibility determination error**
- **As the result of a formal grievance filed by the member against the DBM or by the DBM against the Member**

- **Just cause (as determined by the State)**

The DBM member is permitted to disenroll without cause during the 90 days following the effective date of the individual's initial enrollment with the DBM and when the State imposes the intermediate sanction in 42 CFR 438.702(a)(3).

___ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

_X_ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i.**_X_** MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

A DBM may not request disenrollment of a member because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the DBM seriously impairs the DBM's ability to furnish services to either the particular member or other members).

All disenrollments are subject to approval by the State.

ii.**_X_** The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii.**_X_** If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv.**_X_** The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

F. Program Integrity

1. **Assurances.**

_X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X__ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Part I. Summary Chart of Monitoring Activities

Each DBM contractor must be either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation (DBR) under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR. Each DBM contractor must be certified by the Rhode Island Department of Health as a health plan under the *Rules and Regulations for Certification of Health Plans* (R23-17.13-CHP) and under the *Rules and Regulations for the Utilization Review of Health Care Services* (R23-17.12-UR).

Table 3 summarizes the State's proposed monitoring plan.

Table 3

Rhode Island's Proposed Section 1915(b) Waiver Monitoring Plan for the DBM Program

Monitoring Activity	Personnel Responsible	Description of Activity	Frequency of Use	How Activity Yields Information About the Area Being Monitored
Consumer Self-Report: State Developed Survey	DHS and contractor	A sample of Medicaid beneficiaries will be surveyed regarding their satisfaction with the DBM/program	Annual	Results will indicate areas of unmet need and areas for improvement
Data Analysis (non-claims): Grievances and appeals data	DHS, contractor, and DBM(s)	Data will be collected from DBM(s)	Quarterly	Data will be used to determine the number of complaints, grievances, and appeals and serve as one mechanism to assess both access to care and quality
Independent	Contractor	This will be a larger-scale	Bi-annual	Assessment will be used to

Assessment		program evaluation that will be fed by all other activities in the monitoring plan.		demonstrate the DBM waiver's ability to improve both access and dental health outcomes
Network Adequacy Assurance	DHS, contractor, and DBM(s)	DBM(s) will provide assurances of the adequacy of the networks for member's to access both preventive and specialty dental services, and will provide supporting documentation for this. DHS and contractor staff will assess the adequacy of the networks including through analysis of grievance and member satisfaction data.	Annual	Ability to access services in a timely fashion is an indication of network adequacy
Performance Measures	DHS and contractors	DBM-provided claims data will be used to assess accomplishment of waiver program goals	Semi-annual	Claims data analyses will afford assessment of the degree to which the waiver program is accomplishing its goals delineated in Section A., Part I. of this waiver proposal.
Periodic Medicaid Provider Comparison	DHS and contractors	DBMs will report their enrolled network dental providers for a comparison to Medicaid network prior to the waiver	Annual	Allows State to evaluate provider network adequacy
Utilization Review (UR)	DHS, contractors, and DBM(s)	This will be a daily activity by DBMs to review dental necessity for certain services and to prior authorize them where required by State policy. DHS and contractors will review UR data periodically to assess DBM compliance with State policy.	Ongoing	Assure compliance with State policy and appropriateness of care and serve as a cost-containment mechanism to assure appropriateness of treatment

Part II: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

_X_ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

___ This is a renewal request.

- ___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ___ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes

___ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: _____

c. Telephone Number:_____

d. E-mail:_____

e. The State is choosing to report waiver expenditures based on
___ date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b.___ PIHP
c.___ PAHP
d.___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
  1.___ Base year data is from the same population as to be included in the waiver.
  2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
  _____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
  _____

For Conversion or Renewal Waivers:

a.___ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
  _____

d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P2: ____

e.____[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a.___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

_____

_____

b.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _____

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total			

	Appendix D5 should reflect this.		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*

Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected**

			member months should correspond)

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to

the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one

of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs

trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future),* the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a**

_____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.
2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.
  i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program.

States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.

3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.

4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine copayment adjustment based on pending SPA.

3.___ Determine copayment adjustment based on currently approved copayment SPA.

4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1.___ No adjustment was necessary

2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.

3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4.___ The State made this adjustment:*

i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**

ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment.	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the

Adjustment	Capitated Program	PCCM Program
	That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

  1.___ No adjustment was made.

  2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of**

programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of

the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

vi.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2.___ An administrative adjustment was made.
i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
ii.___ Cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):
iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e.,*

trending from 1999 to present). The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the

capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

ATTACHMENT A

DENTAL SERVICES COVERAGE POLICY

ATTACHMENT B

COMMUNICATIONS PLAN

DBM Communications Plan- 2005/2006

Activities	Aug	Sept	Oct	Nov	Dec	Jan
1. Develop description of DBM						
2. Create fact sheet or brochure/ Create website page						
3. Disseminate information on DBM to DHS' internal groups						
4. Disseminate information on DBM to external groups						
5. Communicate to members (parents of children on Medicaid who are < 6 y.o.)						

DHS internal groups-

CCFH
DHS Management
DHS Regional Managers
DHS Field Staff

External groups-

RC Consumer Advisory Committee
Covering Kids & Family
Family Resource Counselor Program
Advocates, Children with Special Health Care Needs/ general
Advocates, by program or group
- Early Intervention Program
- CEDARR Family Centers
- Leadership RoundTable
- Interagency Coordinating Council (EI)

Advocates, Dental community
Dentists and other dental providers
Dental safety net providers
Dental Associations
- RI Dental Association
- RI Dental Hygienists Association

School-based, school nurses
School-based, Dental Screening Program
School-based, Providence Smiles Program
Other state agencies
- Dept. of Health
- Dept. of Children, Youth and Families
- Children's Cabinet

RI Legislature
Robert Wood Johnson Foundation
Health Plans (NHP, UHC, BCBS)

DBM Communications Plan- 2006						
Activities	Feb	March	**April**	May	June	July
6. Proposed 1st month of enrollment in DBM						
7. Marketing to Dental Providers and ongoing technical assistance						
8. Consumer education on Dental Health (specific topics to be determined).						
9. Coordination of special event or publicity for Children's Dental Health Month (see #8 above)						
10. Ongoing external communications re: DBM						

ATTACHMENT C

WAIVER IMPLEMENTATION PLAN

WAIVER IMPLEMENTATION PLAN

Internal Senior Management Briefings	July and Aug. 2005
Health Plan & Dental Community Project Update	July and Aug. 2005
Communications Preparation (Internal & External) Begins	Aug. 2005
1915(b) Waiver Public Comment Period Begins (30 Days)	Sept. 2005
Release Draft Bid Specifications to Potential Bidders for Comment	Sept. 2005
DBM Data Book Release	Sept. 2005
Final Procurement Document Release	Sept. 2005
DHS Policy Review Process Begins (60 Days)	Sept. 2005
MMIS Modification Process Begins (90 Days)	Sept. 2005
1915(b) Waiver Application Submission (90 Days)	Oct. 2005
DBM Vendor Proposal Deadline	Oct. 2005
Proposal Review Process Begins	Oct. 2005
Contract(s) with DBM(s) Signed	Dec. 1, 2005
Identification of Eligibles to DBM(s)	Dec. 10, 2005
DBMs Readiness Evaluation by DHS	Dec. 2005
Enrollment of Children Begins	**Jan. 2006***

* This is a target date. Children will not be enrolled in a DBM until after the effective data of the waiver

ATTACHMENT D

STATE NOTICE PROCEDURES

ATTACHMENT D

STATE NOTICE PROCEDURES

To fulfill its obligations to comply with 42 CFR 447.225, as guided by the CMS Regional Office in Boston, the State undertook the following public notice process:

- DHS put the "final draft" of the Waiver Application on the agenda of the Child and Family Health Consumer Advisory Council for discussion

- DHS put a notice in English and Spanish in the *Providence Journal*, the newspaper of widest circulation in the State, making the public aware that the "final draft" of the Waiver Application was available for review and how to obtain a copy of it. DHS had a 30-day comment period. A copy of the notice is attached.

- With there being no comments received from the public, the Waiver Application was finalized and copies were forwarded to CMS Central and Regional Offices.

PUBLIC NOTICE

The Department of Human Services (DHS) will contract with a Dental Benefits Manager (DBM) for children on RI Medicaid born after January 1, 2000 for dental services. The DBM will change the delivery of dental services for children who are eligible, but not the covered benefits allowed under Medicaid. The intent of the DBM is to increase access to preventive dental care services for children.

DHS is submitting a 1915(b) waiver application to the Centers for Medicare and Medicaid Services for federal approval and is seeking public input on this initiative. The draft waiver application is available at www.dhs.ri.gov under "Documents for Public Review" or by calling DHS at 462-2187. Please submit comments to DHS by November 4, 2005 at the following email address sreniere@dhs.ri.gov or:

Sharon Reniere
Rhode Island Department of Human Services
Center for Child and Family Health
600 New London Avenue
Cranston, Rhode Island 02920

ATTACHMENT E

RHODE ISLAND MANAGED CARE EXPERIENCE UNDER FEDERAL WAIVERS

ATTACHMENT E

RHODE ISLAND MANAGED CARE EXPERIENCE UNDER FEDERAL WAIVERS

In November of 1993, the State of Rhode Island was granted a Section 1115 waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

RIte Care was initially designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[7] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Over time, the populations eligible for RIte Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured

[7]Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF), FIP is Rhode Island's program for the TANF-eligible population.

- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured

- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act through a State Plan Amendment (SPA))

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

- Effective December 1, 2000, to maximize enrollment of children in foster care placements[8] from fee- for-service Medicaid to RIte Care

- Effective November 1, 2002, to establish a separate child health program to cover unborn children with family income up to 250 percent of the FPL

- Effective January 29, 2003, to enroll the following categories of children with special health care needs into RIte Care Health Plans on a mandatory basis[9]:

    - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)

    - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)

    - Children receiving subsidized adoption assistance

The May 1, 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children's Health Insurance Program, or SCHIP) of the Social Security Act. By Section SCHIP 1115 waiver approval (21-W-00002/1-01), effective January 18, 2001, Section 1931 parents and relative caretakers between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. Approved April 17, 2003, the separate child health program allows the State to provide comprehensive coverage for pregnant aliens who would not be otherwise eligible for Federal financial participation (FFP). These women are enrolled in RIte Care Health Plans.

It should be noted that the State received approval from the, then, Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS)) on January 5, 1999 to expand SCHIP coverage to children under age 19 in households

[8] Children in foster care are in enrolled in RIte Care on a voluntary basis.
[9] Children with special health care needs are also presently enrolled on a voluntary basis, as only one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI) has been willing to enroll this population. NHPRI is also the only Health Plan that has been willing to enroll children in foster care.

with income up to 300 percent of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to ongoing budgetary constraints.

The State has made a number of improvements over time to make the application and enrollment processes less burdensome, to stimulate enrollment, and to deter *crowd-out* (i.e., substituting public coverage for private coverage). Among these administrative improvements have been the following:

- *October 1998* – Implemented a streamlined mail-in application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility

- *April 1999* – Initiated a RIte Care community-based enrollment outreach project, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance-based incentives for locating and enrolling eligible children. This outreach project ended in June 2000.

- *January 2002* – Implemented monthly premiums at up to three percent of income for expansion enrollees over 150 percent of the FPL

- *August 2002* – Increased the monthly premiums but not to exceed five percent of income for expansion enrollees over 150 percent of the FPL

- *May 2004* – Made the RIte Care application available on-line in both English and Spanish

As noted at the beginning of this section, the State made a policy decision to only allow State-licensed HMOs to participate in RIte Care. There were originally five RIte Care-participating Health Plans: Coordinated Health Partners (CHP, or BlueCHiP), Harvard Community Health Plan (HCHP), Neighborhood Health Plan of Rhode Island (NHPRI), Pilgrim Health Care (PHC), and United HealthCare of New England (UHCNE). There have been several important changes to the Rhode Island HMO marketplace since then. First, HCHP and PHC merged in 1995, becoming Harvard Pilgrim Health Care (HPHC). Second, HPHC left[10] the Rhode Island market without warning in 1999. Finally, Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004.

In order to assure the availability of choices for RIte Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in RIte Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a health plan in the State

[10] Tufts Health Plan of New England also left the Rhode Island market about the same time, although it had never participated in RIte Care.

- Be accredited[11] by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO)

- Meet certain State regulatory requirements[12] that HMOs must meet:

  - Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)

  - Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts

  - Meet "preventive health care services" requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender

  - Have a quality management program that is accredited

RIte Share, the State of Rhode Island's premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI), had the following implementation timelines:

- *February 2001* – Initiated voluntary enrollment in RIte Share

- *April 2001* – Began transitioning RIte Care enrollees with access to ESI to RIte Share

- *February 2002* – Began mandatory enrollment in RIte Share of eligibles with access to qualified ESI

Under RIte Share, DHS pays all or a part of an eligible family's monthly premium, based upon income and family size, for an employer's DHS-approved ESI. RIte Share provides for coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments and deductibles.

[11] In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an "excellent" designation from NCQA. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.

[12] *Rules and Regulations for the Certification of Health Plans* (R23-17.13-CHP).

DENTAL SERVICES COVERAGE POLICY 300-45

Introduction

Dental services are a benefit to eligible recipients under the Rhode Island Medical Assistance Dental Services Program.

General Policy Requirements

The Medical Assistance Program will only reimburse providers for medically necessary services. The Medical Assistance Program conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the Medical Assistance Program, trained medical consultants, and independent State and private agencies under contract with the Medical Assistance Program. Services that are denied by Medicare because they are not medically necessary are not reimbursable by the Medical Assistance Program.

Providers must bill the Medical Assistance Program at the same usual and customary rates as charged to the self-pay general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medical Assistance. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

Purpose of Coverage Policy

The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for medical assistance under the Medical Assistance Program. The General Rules for the Medical Assistance Program and the rules in this policy are to be used together to determine eligibility for services.

Recipient Eligibility

The Medical Assistance Program provides coverage for necessary medical services to recipients who are in two basic benefit levels: Categorically Needy and Medically Needy. The scope of services varies according to the benefit level. Refer to Section 100-40 in the Provider Reference Manual for further information.

Recipient Eligibility Verification System (REVS)

For automated benefits and Rhode Island Medical Assistance recipient eligibility information/Customer Service access, in-state long distance providers can access the system by dialing (800) 964-6211. Local and out-of-state providers can access REVS by dialing (401) 784-8100. Modem access to REVS is available. If you are interested in obtaining modem access please call the Customer Service Help Desk at (401) 784-8100. For more information regarding REVS please see Section 100-40 of the Provider Reference Manual.

Retroactive Eligibility

Procedures billed retrospectively for recipients who have retroactive eligibility are valid if all conditions for billing are met.

Scope of Services

The Medical Assistance Program provides payment only for services that are included in the scope of services described in the DHS Manual at Section 033.20, Section 0348 for the RIte Care Program, or under a waiver program at Section 0398; or for recipients under the age of 21 pursuant to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, for additional services that are not included in the above sections, and that are definable under Section 1905(a) of the federal Social Security Act. Specific details of services covered and limitations thereon are contained in the Medical Assistance Program Provider Reference Manuals, the Rhode Island Title XIX State Plan, Section 1115 and Section 1915 Waiver requests, and the RIte Care Program Managed Care Plan and Contracts. Payment is not made for services other than those described herein.

Medical Necessity

The Medical Assistance Program provides payment/allowance for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status.
Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Appeal of Denial of Medical Necessity

Determinations made by the Medical Assistance Program are subject to appeal by the recipient only. Providers may not appeal denials of Medical Necessity.

Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. The route of appeal for Title XIX recipients is through the Department of Human Services. RIte Care participants may first appeal through the managed care plan, or may appeal directly through the Department of Human Services.
(Appeals rights and procedures are contained in DHS Manual Sections 0110 and 0348.)

Medical Assistance payments are provided only for covered services that are determined to be medically necessary. No Medical Assistance payment will made for a medical procedure of an investigative or experimental nature.

Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the Health Care Quality, Financing and Purchasing Division, and also by individuals and organizations under contract to the Department of Human Services. Policies relative to medical necessity are set forth in the DHS Manual, the Medical Assistance Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act.

Approval of Medical Necessity

The Medical Assistance Program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgement of the Medical Assistance Program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity.

Investigative/Experimental Medical Procedures

Medical procedures of an investigative or experimental nature are not covered by the Medical Assistance Program.

A service that is furnished for research purposes in accordance with medical standards is considered experimental or investigational. A procedure is determined to be investigative or experimental according to the current judgment of the medical community as evidenced by medical research, studies, journals or treatises.

The Medical Assistance Program determines whether a treatment, procedure, facility, drug, or supply (each of which is hereafter called a "service") is experimental or investigational. Medical Assistance uses the following criteria to determine if a service is experimental of investigational:

1. The service is not yet approved by the appropriate governmental regulatory body or the service is approved for a purpose other than the purpose for which it is furnished; or

2. Demonstrated reliable evidence shows the service is (a) the subject of ongoing Phase I or II clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; (b) the subject of a written investigational or research protocol; or (c) the subject of a written informed consent use by the treating facility when the written consent is obtained to assure that the patient acknowledges the non-standard nature of treatment.

Demonstrated Reliable Evidence

Demonstrated reliable evidence means: evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature; and/or final approval of the service from the appropriate governmental regulatory body, demonstrating:

a) definite, measurable, positive effects of the service on health outcomes, with results supported by positive endorsements of national medical bodies or panels regarding their scientific efficacy and rationale; and proof that, over time, the beneficial effects of the service outweigh any harmful effects;

b) risk-benefit ratios as factorable as, if not better than, those of conventional treatments and significant advantages over such conventional treatments;

c) improvement in health outcomes possible under the standard conditions of medical practice, outside the clinical investigatory settings;

d) the service is at least as beneficial in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

Denial of Medical Necessity

When the Medical Assistance Program is requested to pay directly (fee-for-service) for a particular service for a recipient who has other third-party coverage (such as Medicare or Blue Cross), for that particular service, if the third party denies payment for services based on medical necessity, this determination is adopted by the Medical Assistance Program. An independent determination of medical necessity is not made in such circumstances. For example, if federal Medicare determines that a home health service is not medically necessary, then that determination is binding on the Medical Assistance Program and Medical Assistance payment of the service cannot be made.

Third Party Liability

The Medical Assistance Program is the payor of last resort. All third party programs must be utilized before any payment can be made by the Medical Assistance Program.

If payment from other third parties is equal to or exceeds the Medical Assistance Program allowable amount, no payment will be made on the claim by the Medical Assistance Program.

The Medical Assistance payment is considered payment in full. The Provider is not allowed to bill the recipient for any additional charges not paid for by the program.
For more detailed TPL information, refer to page 300-TPL-1 through 300-TPL-11 for further information.

Provider Participation

Dental providers must be licensed by the Rhode Island Department of Health, or by the appropriate agency in the state in which they practice, and enrolled in the Medical Assistance Program to receive reimbursement for dental services.

Recertification

Providers are periodically recertified by the Department of Health (DOH). Providers obtain license renewal through DOH and then forward a copy of the renewal documentation to EDS. EDS should receive this information at least five business days prior to the expiration date of the license. Failure to do so will result in suspension from the program.

A provider may appeal to the DOH if the facility does not meet the recertification criteria. If the appeal to DOH is not successful, the provider may then appeal to the Centers for Medicare and Medicaid (CMS).

Claims Billing Guidelines

Dental claims must be billed on one of the ADA-approved dental claim forms. It is recommended that the most recent ADA dental form be used for billing. Instructions for completing the ADA dental claim form are located in Section 400-10 of the Provider Reference Manual.

Reimbursement Guidelines

The Medical Assistance Program will not pay for canceled or missed office visits.

Prior Authorization of Payment

For some procedures, prior authorization is required before services are performed, unless the service is an emergency.

Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies or traumatic injuries. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

Prior authorization for all inpatient admissions must follow the procedures outlined in Service Utilization Review and Admission Screening, Section 100-70, in the Provider Manual.
Prior authorization does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service by checking the Recipient Eligibility Verification System (REVS). Refer to Section 100-40 in the Provider Manual as well as the REVS User Guide.

If there is a verifiable emergency service which requires prior authorization, and needs to be done immediately, the procedure should be performed and the reason written on the claim form. The consultants will review these claims and consider them for payment. The Medical Assistance Program Dental policy designates those codes which require prior authorization.

Payment for any prior authorization services can only be made if the services are provided while the person remains eligible for the Rhode Island Medical Assistance Program. If the case is closed after prior authorization has been granted, but before treatment has been completed, only those services provided while the person was eligible can be considered for payment by the Rhode Island Medical Assistance Program.

Services Reviewed by Medical Assistance

The Medical Assistance Program reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.

Consultants

The Office of Medical Assistance Programs, in consultation with the Rhode Island Dental Association, contracts with General Practice consultants, Oral Surgery consultants, and Orthodontic consultants for professional review of specific services or billings before payment will be authorized by the Medical Assistance Program.

If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied.

The Rhode Island Dental Association will be requested to provide peer review on specific issues through the regularly established peer review system of the Association. The prevention of fraud and abuse may be pursued at the discretion of the Rhode Island Medical Assistance Program and is not limited to Rhode Island Dental Association peer review.

Individual Consideration

Request for payment for dental services listed as “IC”, or services not included in the procedure code listing, must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or X-rays. Payment for "IC" procedures will be approved in consultation with a Medical Assistance dental consultant.

Medical Assistance Requests for X-Rays

Medical Assistance, in the process of utilization review and/or in determining its responsibility for payment of dental services, may request the treating dentist to submit appropriate X-rays and/or other clinical information which justifies the treatment to the Medical Assistance Program. Payment may be denied if the requested X-rays and/or other clinical information are not submitted. Any procedure for which prior authorization was not required must be verified, as necessary, by pre-operative and post-operative X-rays or other means prior to payment.

Prior approval for routine diagnostic x-rays for determination of course of treatment will be denied. Prior authorization for these radiographs should only be requested in those instances in which the need for the x-rays is in excess of the dental community standard of care. Routine diagnostic x-rays are considered to be part of the cost of treatment.

The Medical Assistance Dental Services Program will provide all persons under the age of 21 with a full range of dental services.

Medical Assistance will use the American Dental Association standard insurance form and the Current Dental Terminology (CDT-4) procedure codes.

Emergency Dental Services

Payments for emergencies are restricted to services defined as "Emergency Services" (see Definitions of Terms in this section below).

Emergency services do not require prior authorization by Medical Assistance. Documentation of the need for the emergency services is the responsibility of the provider and subject to audit by Medical Assistance.

Service Utilization Review and Admission Screening

Refer to Section 100-70 in the General Provisions section of the Provider Reference Manual.

Procedures Never Considered Emergencies

The following procedures are never considered to be of an emergency nature:

Appliances (not related to immediate trauma/injury)
Dentures, full or partial
Exostosis (Tori) removal
Flippers (stay plates)
Frenectomy, Frenulectomy
Gingivectomy, Gingivoplasty
Remake or repair of Archwire
Space maintainers
Tissue Conditioning

Services Considered Part of Total Treatment - Not Separate Services

The following services do not warrant an additional fee and are considered to be either minimal services that are included in the examination, part of another service, or included in routine post-op or follow-up care:

Cardiac Monitoring
Dietary Counseling
Dressing Change
Electrosurgery
Equilibration of Occlusion
Local Anesthesia
Medicated Pulp Chambers
Odontoplasty
Periodontal Charting, Probing
Post Extraction Treatment for Alveolitis
Suture Removal
File Broken Tooth
Special Infection Control Procedures
Alveolectomy, in Conjunction with Extractions
Pulp Vitality Tests
Diagnostic Cast construction (study models)
Oral Hygiene Instruction
Surgical procedure for isolation of tooth with rubber dam
Surgical Stent construction
Surgical Splint construction
Direct and Indirect Pulp Capping
Diagnostic Photographs
Analgesia

Definition of Terms

Emergency Services

Emergency Services are covered services requiring immediate treatment. This includes services to control hemorrhage, relieve pain, eliminate acute infection. This includes immediate treatment of injuries to both dentition and supporting structures, but does not include permanent restorations.

The emergency rule applies only to covered services. Some non-covered services may meet the criteria of emergency, but it is not intended to extend to those non-covered services. Routine dental treatment of incipient decay does not constitute emergency care.

Preventive Services

This includes the following services:

Oral Prophylaxis (cleaning of teeth)
Topical Fluoride Treatment
Placement of Sealants
Space maintainers for prematurely lost primary posterior teeth

Therapeutic Services

This includes the following services:

Pulp therapy of permanent and primary teeth - restricted to recipients under age 21

Restorations of primary and permanent teeth using amalgam, composite materials and/or stainless steel or polycarboxylate crowns

Subgingival scaling and curettage

Removable prostheses when masticatory function is impaired such as is found with less than six (6) opposing teeth.

Covered Services

Covered Services are those services that will be reimbursed to a provider for an eligible recipient as defined in the Dental Services Provider Reference Manual.

General Anesthesia

General Anesthesia is defined as a controlled state of unconsciousness including the inability to independently maintain an airway or to respond purposefully to physical stimulation or verbal command – restricted to recipients under age 21 only.

The use of the following drugs either alone or in combination with other drugs is conclusively presumed to produce general anesthesia:

Ultra short acting barbiturates including but not limited to sodium methohexital, thiopental, thiamylal,

Other general anesthetics including, but not limited to, ketamine or etomidate; or

Rapidly acting steroids including, but not limited to, althesin.

Sedation

Sedation involves the administration of a sedative drug intravenously (in a single injection or injected over an extended period of time), intramuscularly, submucosally, or subcutaneously.

Restricted to individuals under age 21

Services with this limitation can only be provided under the Rhode Island Medical Assistance Dental Services Program to individuals who have not attained their 21st birthday prior to the delivery of the service.

Services Not Covered

Procedure codes not listed in the Medical Assistance Dental Fee Schedule are services not covered under the Medical Assistance Dental Services Program. The following general categories of dental services are not covered, except if deemed medically necessary for patients under 21 years of age.

Desensitization
Fixed Bridges
Extensive Periodontal Surgery
Crowns for Bicuspids and Molars
Root Canal Therapy for Bicuspids and Molars
Occlusal Equilibration
Implants
Crowns (Types: ceramco, gold, or other full cast, and porcelain fused to metal)

Nursing Home Services

Payment is covered for Medical Assistance recipients for dental services provided in a nursing home or long-term care facility by reporting the appropriate code in addition to the code for actual dental services performed.

The fees for all endodontic and oral surgery procedures includes the fee for the examination and necessary X-rays.

Covered Services

The following dental services and procedure codes are covered by the Medical Assistance Program with limitations, where noted.

Explanation of Symbols

Age Restrictions	**Prior Authorization (PA) Requirements**
<21 – Service can only be provided to recipients under age 21.	**N** – No PA Required
N – No age restrictions	**Y** – PA is Required

DIAGNOSTIC SERVICES

Clinical Oral Examinations A Comprehensive Oral Evaluation is defined as the first exam for a new patient in the dental office. This replaced the initial Oral Exam and each recipient is limited to one Comprehensive Oral Exam per lifetime from the same provider. Each exam after the Comprehensive exam will be paid on the basis of a periodic exam.

The codes in this section have been revised to recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.

		Age Restriction	PA Requirement
D0120	**Periodic Oral Evaluation** An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. *This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.* ***Periodic exams are allowed twice per calendar year, per recipient.***	**N**	**N**
D0140	**Limited Oral Evaluation - problem focused** An evaluation or re-evaluation limited to a specific oral health problem. *This may require interpretation of information acquired through additional diagnostic procedures*. Emergency examinations based on documented need are allowed per emergency episode. *Definitive procedures may be required on the same date as the evaluation.* *Do not bill for an emergency examination for each visit during the treatment.* Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.	**N**	**N**
D0150	**Comprehensive Oral Evaluation** Replaces the former Initial Oral Evaluation procedure. Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional procedures should be reported separately.	**N**	**N**

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions, including periodontal charting hard and soft tissue anomalies, etc.

		Age Restriction	PA Requirement
D0160	**Detailed and Extensive Oral Evaluation – problem focused, by report**	**N**	**N**

A detailed and extensive problem-focused evaluation of a specific oral health issue. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required based on the findings of a Comprehensive Oral Evaluation. The condition requiring this type of evaluation should be described and documented.

Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, severe systemic diseases requiring multidisciplinary consultation, etc.

RADIOGRAPHS / DIAGNOSTIC IMAGING

Radiographs / diagnostic imaging are appropriate only for clinical reasons as determined by a dentist. The films should be of diagnostic quality and properly identified and dated. The results are a part of the patient's clinical record and the original films should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

Radiographs

The Medical Assistance Program will allow items in accordance with the provisions of Dental Services policy, with the following limitations:

Intraoral-complete series (D0210) are allowed once every 1460 days (four years).

X-rays for routine screening, i.e., Bitewing services - single film (D0270), two films (D0272), and four films (D0274), are allowed once every calendar year, per client. D0274 cannot be performed with D0272 on the same day.

Panoramic films (D0330) are limited to one every 1460 days (four years).

Payment for some or all multiple X-rays of the same tooth or area may be denied if Medical Assistance determines the number to be excessive.

The total payment for periapicals and/or other radiograph cannot exceed the payment for a complete intraoral series.

D0210 Intraoral-complete series (including bitewings).

Number of films required is dependent upon age of patient -in no case are less than eight films required. Adults and children over 12 require 12-20 films, as is appropriate. Limited to one every 1460 days. (four years)

X-rays and/or other diagnostic verification are required with the claim when requesting prior authorization for the following procedures:

- Fixed prosthodontics
- Orthodontic requests
- Periodontal treatment
- Removable prosthodontics
- Endodontic procedures
- Oral Surgical procedures

X-rays should be:

- Originals or duplicates
- Mounted
- In envelope, stapled to invoice
- Clearly labeled with dentist's name, address and patient's name

		Age Restriction	PA Requirement
D0210	**Intraoral - complete series (including bitewings)**	**N**	**N**
D0220	**Intraoral - periapical - first film**	**N**	**N**
D0230	**Intraoral - periapical - each additional film**	**N**	**N**
D0240	**Intraoral - occlusal film**	**N**	**N**
D0250	**Extraoral - first film**	**N**	**N**
D0260	**Extraoral - each additional film**	**N**	**N**
D0270	**Bitewing - single film**	**N**	**N**
D0272	**Bitewings - two films**	**N**	**N**
D0274	**Bitewings - four films**	**N**	**N**
D0290	**Posterior-anterior or lateral skull and facial bone survey film**	**N**	**Y**
D0310	**Sialography**	**N**	**Y**
D0320	**Temporomandibular joint arthrogram, including injection**	**N**	**Y**
D0321	**Other temporomandibular joint films, by report**	**N**	**Y**
D0322	**Tomographic survey**	**N**	**Y**
D0330	**Panoramic film**	**N**	**N**
D0340	**Cephalometric film**	**⟨21**	**Y**

TESTS AND LABORATORY EXAMINATIONS

Tests and Laboratory — The following procedures have no prior authorization or age limitations and will be priced individually based on submission and review of all medical information.

D0502	**Other oral pathology procedures, by report** Refers to gross and microscopic evaluations of presumptively abnormal tissue(s).	**N**	**N**
D0999	**Unspecified diagnostic procedure, by report** Used for procedure which is not adequately described by a code. Describe procedure.	**N**	**N**

DENTAL PROPHYLAXIS

PREVENTIVE SERVICES Prophylaxis - Allowed twice every calendar year.		Age Restriction	PA Requirement
D1110	**Prophylaxis – adult** A dental prophylaxis performed on transitional or permanent dentition which includes scaling and/or polishing procedures to remove coronal plaque, calculus and stains.	**⟩12**	**N**
D1120	**Prophylaxis – child** Refers to a routine dental prophylaxis performed on primary or transitional dentition only.	**⟨13**	**N**

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

Topical Fluoride Treatment (Office Procedure) Allowed twice every calendar year for recipients under 21 years of age.

Covered for recipients 21 years of age or older only if deemed medically necessary.

Fluoride must be applied separately from prophylaxis paste.
Application does not include fluoride rinses or "swish".

		Age Restriction	PA Requirement
D1201	**Topical application of fluoride (including prophylaxis) – child** Used to report combined procedures of prophylaxis and fluoride treatment.	**⟨21**	**Y**
D1203	**Topical application of fluoride (prophylaxis not included)-child** Used when reporting prophylaxis and fluoride procedures separately.	**⟨21**	**N**
D1204	**Topical application of fluoride (prophylaxis not included)-adult** Used when reporting prophylaxis and fluoride procedures separately	**⟩20**	**N**

OTHER PREVENTIVE SERVICES

Sealants Sealants are covered only for permanent molars for patients under 21 years of age. One treatment per tooth every five years. When billing for this service, the occlusal surface must be reported on the claim form.

D1351	**Sealant - per tooth** Mechanically and/or chemically prepared enamel surface sealed to prevent decay.	**<21**	**N**

Payment for sealant is not allowed when an occlusal restoration exists.
Payment for a sealant is not allowed on teeth #1, 16, 17, and 32.

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Space Maintenance Service is limited to recipients under 21 years of age. Removable space maintainers will not be replaced if lost or damaged. Medical Assistance will only pay once for recementation of any space maintainer (D1550). Passive appliances are designed to prevent tooth movement.

		Age Restriction	PA Requirement
D1510	**Space maintainer - fixed - unilateral**	**⟨21**	**N**
D1515	**Space maintainer - fixed - bilateral**	**⟨21**	**N**
D1520	**Space maintainer - removable - unilateral**	**⟨21**	**N**
D1525	**Space maintainer - removable - bilateral**	**⟨21**	**N**
D1550	**Recementation of space maintainer**	**⟨21**	**N**

RESTORATIVE SERVICES

**** Local anesthesia is considered to be part of restorative procedures.***

AMALGAM RESTORATIONS (INCLUDING POLISHING)		Age Restriction	PA Requirement
D2140	**Amalgam - one surface, primary or permanent**	**N**	**N**
D2150	**Amalgam - two surfaces, primary or permanent**	**N**	**N**
D2160	**Amalgam - three surfaces, primary or permanent**	**N**	**N**
D2161	**Amalgam - four or more surfaces, primary or permanent**	**N**	**N**

All adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

Filled or Unfilled Resin Restorations

Resin restorations are allowed only on anterior teeth for recipients >20 years old.

RESIN-BASED RESTORATIONS - DIRECT

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

		Age Restriction	PA Requirement
D2330	**Resin - one surface, anterior**	**N**	**N**
D2331	**Resin - two surfaces, anterior**	**N**	**N**
D2332	**Resin - three surfaces, anterior**	**N**	**N**
D2335	**Resin - four or more surfaces or involving incisal angle** (anterior)	**N**	**N**

Restorative Procedures for Recipients Under 21 The following Restorative procedures are covered by the Medical Assistance Program only for individuals under age 21. No prior authorization is required.

D2390	**Composite resin crown, anterior-primary** Full resin-based composite coverage of tooth.	**⟨21**	**Y**
D2391	**Resin-based composite - one surface, posterior** Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	**⟨21**	**N**
D2392	**Resin-based composite - two surfaces, posterior**	**⟨21**	**N**
D2393	**Resin-based composite - three surfaces, posterior**	**⟨21**	**N**
D2394	**Resin-based composite – four or more surfaces, posterior**	**⟨21**	**N**

Individual Crowns

Payment for crowns for anterior teeth, permanent or primary, is limited to prefabricated resin crowns.

Payment for crowns for posterior teeth, permanent or primary, is limited to stainless steel crowns.

Payment for preparation of the gingival tissue is included in the fee for the crown.

Retention pins are limited to two per tooth in addition to restoration during a 365 day period.

The Medical Assistance Program will only pay once per tooth per calendar year for recementation of inlays and crowns (D2910 & D2920).

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial.)

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.

A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extends beyond the line angle.
A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.

A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal edge is involved.

CROWNS - SINGLE RESTORATIONS ONLY

Classification of metals - The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content: **high noble** - Gold (Au), Palladium (Pd), and/or Platinum (Pt) $\leq$ 60% ($\geq$ 40% Au); **noble** - Gold (Au), Palladium (Pd), and/or Platinum (Pt) $\geq$ 25%; **predominantly base** - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

		Age Restriction	PA Requirement
D2710	**Crown - resin (indirect)**	**⟨21**	**N**
D2720	**Crown - resin with high noble metal**	**⟨21**	**N**
D2721	**Crown - resin with predominantly base metal**	**⟨21**	**N**
D2722	**Crown - resin with noble metal**	**⟨21**	**N**
D2740	**Crown - porcelain/ceramic substrate**	**⟨21**	**N**
D2750	**Crown - porcelain fused to high noble metal**	**⟨21**	**N**
D2751	**Crown - porcelain fused to predominantly base metal**	**⟨21**	**N**
D2752	**Crown - porcelain fused to noble metal**	**⟨21**	**N**
D2790	**Crown - full cast high noble metal**	**⟨21**	**N**

		Age Restriction	PA Requirement
D2791	**Crown - full cast predominantly base metal**	**⟨21**	**N**
D2792	**Crown - full cast noble metal**	**⟨21**	**N**
OTHER RESTORATIVE SERVICES			
D2910	**Recement inlay**	**N**	**N**
D2920	**Recement crown**	**N**	**N**
D2930	**Prefabricated stainless steel crown - primary tooth**	**N**	**N**
D2931	**Prefabricated stainless steel crown - permanent tooth**	**N**	**N**
D2932	**Prefabricated resin crown**	**N**	**N**
D2933	**Prefabricated stainless steel crown with resin window** Open-face stainless steel crown with aesthetic resin facing or veneer.	**⟨21**	**N**
D2940	**Sedative filling** Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	**N**	**N**
D2950	**Core buildup, including any pins** Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.	**N**	**N**
D2951	**Pin retention - per tooth, in addition to restoration**	**⟨21**	**N**
D2952	**Cast post and core in addition to crown** Cast post and core is separate from crown.	**⟨21**	**N**
D2954	**Prefabricated post and core in addition to crown** Core is built around a prefabricated post. This procedure includes the core material.	**N**	**N**
D2970	**Temporary crown (fractured tooth)** A preformed artificial crown, usually made of stainless steel or resin, which is fitted over a damaged tooth as an immediate protective device in tooth injury.	**⟨21**	**Y**
D2980	**Crown repair, by report** Includes removal of crown, if necessary. Describe procedure.	**N**	**Y**

		Age Restriction	PA Requirement
D2999	**Unspecified restorative procedure, by report** Use for procedure which is not adequately described by a code. Describe procedure. (Based on Individual Consideration (IC) upon submission and review of all necessary medical information..)	**N**	**Y**

ENDODONTICS

**** Local anesthesia is considered to be part of endodontic procedures.***

Includes primary teeth with no permanent successor and permanent teeth.

Complete root canal therapy: Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

Pulp Capping Direct and indirect pulp caps are included in the restoration fee. No additional payment will be made.

PULPOTOMY Therapeutic pulpotomies, excluding final restoration, are limited to recipients under age 21.

Therapeutic pulpotomy (D3220) is allowed only for calcium hydroxide pulpotomies on permanent teeth with vital exposed pulps, incompletely formed root apices, and formocresol pulpotomies on deciduous teeth.

Recipients are limited to one (1) pulpotomy per deciduous tooth per lifetime.

		Age Restriction	PA Requirement
D3220	**Therapeutic pulpotomy (excluding final restoration) Removal of pulp coronal to the dentinocemental junction and application of medicament** Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. • To be performed on primary or permanent teeth. • This is not to be construed as the first stage of root canal therapy.	**N**	**N**

ENDODONTIC SERVICES (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

Root Canal Therapy Separate reimbursement for open and drain or pulpotomy procedures is only allowed when the root canal is not completed. In that circumstance, these procedures will be reimbursed as a palliative treatment (D9110).

Root canal therapy is limited to one (1) procedure per tooth, per recipient, per lifetime.

Root canal therapy is limited to permanent teeth, and only if the treatment will lead to a favorable prognosis. The only time that root canal therapy may be performed on primary teeth is: (1) when there is no permanent successor; and (2) on primary second molars prior to eruption of the first permanent molar.

The fee for endodontic procedures is inclusive of all examinations and diagnostics. On patients age 21 and older, anterior root canals will only be paid for (1) if all three anterior teeth are present in the involved arch, or (2) if the involved tooth cannot be added to an existing or proposed partial denture and the tooth will not need a post and core and/or crown to be restored.

		Age Restriction	PA Requirement
D3310	**Anterior (excluding final restoration)**	**N**	**N**
D3320	**Biscuspid (excluding final restoration)**	**⟨21**	**N**
D3330	**Molar (excluding final restoration)**	**⟨21**	**N**

APEXIFICATION/RECALIFICATION PROCEDURES

Apexification is limited to a maximum of five treatments on permanent teeth only and is limited to recipients under age 21.

D3351	**Apexification/recalcification - initial visit (Apical closure/calcific repair of perforations, root resorption, etc.)** Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.)	**⟨21**	**N**
D3352	**Apexification/recalcification - interim medication replacement (Apical closure/calcific repair of perforations, root resorption, etc.)** For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.	**⟨21**	**N**
D3353	**Apexification/recalcification - final visit (Includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)** Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)	**⟨21**	**N**

APICOECTOMY/PERIRADICULAR SERVICES

Periradicular surgery is a term used to describe surgery to the root surface, (e.g., apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

		Age Restriction	PA Requirement
D3410	**Apicoectomy/periradicular surgery – anterior** For surgery on root of anterior tooth. Does not include placement of retrograde filling material.	**⟨21**	**N**
D3421	**Apicoectomy/periradicular surgery- bicuspid (first root)** For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is Treated, see D3426.	**⟨21**	**Y**
D3425	**Apicoectomy/periradicular surgery - molar (first root)** For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.	**⟨21**	**Y**
D3426	**Apicoectomy/periradicular surgery (each additional root)** Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.	**⟨21**	**N**
D3430	**Retrograde filling - per root** For placement of retrograde filling material during periradicular surgery procedures. If more than one filling placed in one root-report as D3999 and describe.	**⟨21**	**N**
D3450	**Root amputation - per root** Root resection of a multirooted tooth while leaving the crown. If the crown is sectioned, see D3920.	**⟨21**	**N**

OTHER ENDODONTIC PROCEDURES

D3920	**Hemisection (including any root removal), not including root canal therapy** Includes separation of a multirooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.	**⟨21**	**N**
D3999	**Unspecified endodontic procedure, by report** Used for procedure which is not adequately described by a code. Describe procedure.	**N**	**Y**

PERIODONTAL SERVICES

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

Periodontal scaling and root planing (D4341) and gingival curettage (D4220) are allowed once every two years. Periodontal charting and X-rays are required. Pockets must be 4mm or greater for approval and are restricted to recipients under age 21.

Records must document the clinical indications for periodontal scaling and root planing and for gingival curettage. Periodontal maintenance procedures (D4910) are allowed once every six months after D4341 and will not be paid during the 6-month period immediately after D4341.

Gingival Flap (D4240) and Osseous surgery (D4260) are allowed once every three years unless there is a documented medical indication.

Cavitron scaling/gross scaling does not qualify for a separate reimbursable fee; the fee is included as part of the global periodontal procedures.

Gingivectomy or gingivoplasty is not covered for those recipients 21 years of age or older except in cases of medically induced gingival hyperplasia, e.g., dilantin hyperplasia.

		Age Restriction	PA Requirement
D4210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant** Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. Performed in shallow to moderate suprabony pockets after adequate initial preparation, for suprabony pockets which need access for restorative density, when moderate gingival enlargements or aberrations are present, and when there is asymmetrical or unesthetic gingival topography.	**N**	**N**
D4211	**Gingivectomy or gingivoplasty – one to three teeth, per quadrant** See D4210 descriptor.	**N**	**N**
D4240	**Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant** Involves surgical debridement of the root surface and the removal of granulation tissue following the resection or reflection of soft tissue flap. Osseous recontouring is not accomplished in conjunction with the procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of probing attachment, need to maintain esthetics, and need for increased access to the root surface and alveolar bone.	**⟨21**	**N**

		Age Restriction	PA Requirement
D4241	**Gingival flap procedure, including root planing - one to three teeth,per quadrant** See D4240 descriptor.	**⟨21**	**N**
D4260	**Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant** This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) or non-supporting bone. Other separate procedures including, but not limited to, D3450, D3920, D4263, D4264, D4266, D4267, and D7140 may be required concurrent to D4260.	**⟨21**	**N**
D4261	**Osseous surgery (including flap entry and closure)- one to three teeth, per quadrant** See D4260 descriptor.	**⟨21**	**N**
D4263	**Bone replacement graft - first site in quadrant** Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. The procedure does not include flap entry and closure and is reported in addition to a procedure that includes flap entry and closure, including, but not limited to D4240, D4260.	**⟨21**	**N**
D4264	**Bone replacement graft - each additional site in quadrant** Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. This code is used if performed concurrently with D4263 - bone replacement graft - first site, per quadrant and allows reporting of the exact number of sites involved.	**⟨21**	**N**
D4266	**Guided tissue regeneration - resorbable barrier, per site,** A membrane is placed over the roof surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.	**⟨21**	**N**

		Age Restriction	PA Requirement
D4267	**Guided tissue regeneration - nonresorbable barrier, per site, per tooth (includes membrane removal)** Used to regenerate lost or injured periodontal tissue by directing differential tissue responses. A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure requires subsequent surgical procedures to remove the membranes and/or to correct the gingival contours. Guided tissue regeneration may be used in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.	⟨21	N
D4270	**Pedicle soft tissue graft procedure** A pedicle flap of gingival tissue can be raised from an edentulous ridge, adjacent teeth, or from the existing gingival tissue on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.	⟨21	N
D4271	**Free soft tissue graft procedure (including donor site surgery)** Gingival or masticatory mucosa is grafted to create or augment the gingival tissue at another site, with or without root coverage. This graft may also be used to eliminate the pull of frena and muscle attachments, to extend the vestibular fornix, and to correct localized gingival recession.	⟨21	N
D4273	**Subepithelial connective tissue graft procedures** This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull, to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingival and/or mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure. After the graft is placed on the recipient site, it is covered with the retained overlying flap.	⟨21	N

		Age Restriction	PA Requirement
D4274	**Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)** Performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.	⟨21	N
ADJUNCTIVE PERIODONTAL SERVICE			
D4320	**Provisional splinting – intracoronal** An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint, by report.	⟨21	N
D4321	**Provisional splinting – extracoronal** An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint, by report.	⟨21	N
D4341	**Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant** Thid procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planning is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.	⟨21	N
D4342	**Periodontal scaling and root planing – one to three teeth, per quadrant** See 4341 descriptor.	⟨21	N
D4355	**Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis** The removal of subgingival and/or supragingival plaque and calculus. This procedure does not preclude the need for additional procedures.	⟨21	N
D4381	**Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report** Synthetic fibers or other approved delivery devices containing controlled-release chemotherapeutic agent(s) are inserted into a periodontal pocket. Short-term use of the timed release therapeutic agent as supplemental or adjunctive therapy provides for reduction of subgingival flora.	⟨21	Y

This procedure does not replace conventional or surgical therapy required for debridement, resective procedures or for regenerative therapy.

The use of controlled-release chemotherapeutic agents is an adjunctive procedure for specific sites that are unresponsive to conventional therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy.

		Age Restriction	PA Requirement
OTHER PERIODONTAL SERVICES			
D49l0	**Periodontal maintenance** For patients who have previously been treated for periodontal disease. Typically, maintenance starts after completion of active (surgical or nonsurgical) periodontal therapy and continues at varying intervals, determined by the clinical diagnosis of the dentist, for the life of the dentition. It includes removal of the supra and subgingival microbial flora and calculus, site specific scaling and root planing where indicated, and/or polishing the teeth. When new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.	**⟨21**	**N**
D4999	**Unspecified periodontal procedure, by report** Used for a procedure which is not adequately described by a code. Describe procedure and submit appropriate medical documentation.	**N**	**Y**

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

Removable Prosthodontics

Removable prosthodontics are limited to the replacement of permanent teeth. X-rays are required.

Recipients are allowed one (1) set of partial and/or complete dentures during an 1825 day (5 year) period from any provider.

Adjustments to dentures during the 183 day (6-month) period following delivery of dentures to recipients are included in the fee.

After the initial 183 day (6-month) period from delivery, a **reline** is allowed once per year as deemed medically necessary.

A **rebase** will be covered 730 days (2 years) from the date of delivery of the dentures and then once every 2 years as deemed medically necessary.

Dentures will not be replaced if lost or damaged for a period of 5 years from the time the dentures were first fabricated.

Interim partial dentures (D5820 & D5821) will only be considered to replace a missing permanent anterior tooth in a patient under 21 years of age. These procedures require a Prior Authorization.

**** Local anesthesia is considered to be part of removable Prosthodontic procedures.***

		Age Restriction	PA Requirement
D5110	**Complete denture - maxillary**	**N**	N
D5l20	**Complete denture - mandibular**	**N**	**N**
PARTIAL DENTURE (INCLUDING ROUTINE POST-DELIVERY CARE)			
D52ll	**Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)** Includes acrylic resin base denture with resin or wrought wire clasps.	**N**	**N**
D52l2	**Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)** Includes acrylic resin base denture with acrylic resin clasps.	**N**	**N**
D5213	**Maxillary partial denture - case metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	**⟨21**	**N**
D5214	**Mandibular partial denture - case metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	**⟨21**	**N**

		Age Restriction	PA Requirement
ADJUSTMENTS TO DENTURES			
D5410	**Adjust complete denture - maxillary**	**N**	**N**
D5411	**Adjust complete denture - mandibular**	**N**	**N**
D5421	**Adjust partial denture - maxillary**	**N**	**N**
D5422	**Adjust partial denture - mandibular**	**N**	**N**
REPAIRS TO COMPLETE DENTURES			
D5510	**Repair broken complete denture base**	**N**	**N**
D5520	**Replace missing or broken teeth - complete denture (each tooth)**	**N**	**N**
REPAIRS TO PARTIAL DENTURES			
D5610	**Repair resin denture base**	**N**	**N**
D5620	**Repair cast framework**	**N**	**N**
D5630	**Repair or replace broken clasp**	**N**	**N**
D5640	**Replace broken teeth - per tooth**	**N**	**N**
D5650	**Add tooth to existing partial denture**	**N**	**N**
D5660	**Add clasp to existing partial denture**	**N**	**N**
DENTURE REBASE PROCEDURES			
Rebase - process of refitting a denture by replacing the base material.			
D5710	**Rebase complete maxillary denture**	**N**	**N**
D57ll	**Rebase complete mandibular denture**	**N**	**N**
D5720	**Rebase maxillary partial denture**	**N**	**N**
D572l	**Rebase mandibular partial denture**	**N**	**N**
DENTURE RELINE PROCEDURES			
Reline - process of resurfacing the tissue side of a denture with new base material.			
D5730	**Reline complete maxillary denture(chairside)**	**N**	**N**
D5731	**Reline complete mandibular denture (chairside)**	**N**	**N**
D5740	**Reline maxillary partial denture (chairside)**	**N**	**N**
D5741	**Reline mandibular partial denture (chairside)**	**N**	**N**

		Age Restriction	PA Requirement
D5750	**Reline complete maxillary denture (laboratory)**	**N**	**N**
D575l	**Reline complete mandibular denture (laboratory)**	**N**	**N**
D5760	**Reline maxillary partial denture (laboratory)**	**N**	**N**
D576l	**Reline mandibular partial denture (laboratory)**	**N**	**N**

OTHER REMOVABLE PROSTHETIC SERVICES

A provisional prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.

D58l0	**Interim complete denture (maxillary)**	**⟨21**	**Y**
D58ll	**Interim complete denture (mandibular)**	**⟨21**	**Y**
D5820	**Interim partial denture (maxillary)** Includes any necessary clasps and rests.	**⟨21**	**Y**
D582l	**Interim partial denture (mandibular)** Includes any necessary clasps and rests.	**⟨21**	**Y**
D5860	**Overdenture - complete, by report** Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.	**N**	**Y**
D586l	**Overdenture - partial, by report** Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.	**N**	**Y**
D5862	**Precision attachment, by report** Each set of male and female components should be reported as one precision attachment. Describe the type of attachment used.	**⟨21**	**Y**
D5899	**Unspecified removable prosthodontic procedure, by report** Use for a procedure which is not adequately described by a code. Describe procedure.	**N**	**Y**

MAXILLOFACIAL PROSTHETICS

Maxillofacial Prosthetics All series CDT D59 - - procedures will be covered by Individual Consideration (IC). Maxillofacial prosthetics services are limited to when medically necessary to correct a handicapping condition.

		Age Restriction	PA Requirement
D5911	**Facial moulage (sectional)** A sectional facial moulage impression is a procedure used to record the soft tissue contours of a portion of the face. Occasionally several separate sectional impressions are made, then reassembled to provide a full facial contour cast. The impression is utilized to create a partial facial moulage and generally is not reusable.	**N**	**N**
D5912	**Facial moulage (complete)** Synonymous terminology: facial impression, face mask impression. A complete facial moulage impression is a procedure used to record the soft tissue contours of the whole face. The impression is utilized to create a facial moulage and generally is not reusable.	**N**	**N**
D5913	**Nasal prosthesis** Synonymous terminology: artificial nose. A removable prosthesis attached to the skin which artificially restores part or all of the nose. Fabrication of a nasal prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed a nasal prosthesis replacement.	**N**	**N**
D5914	**Auricular prosthesis** Synonymous terminology: artificial ear, ear prosthesis. A removable prosthesis which artificially restores part or all of the natural ear. Usually, replacement prostheses can be made from the original mold if tissue bed changes have not occurred. Creation of an auricular prosthesis requires fabrication of a mold, from which additional prostheses usually can be made, as needed later (auricular prosthesis, replacement).	**N**	**N**

		Age Restriction	PA Requirement
D5915	**Orbital prosthesis** A prosthesis which artificially restores the eye, eyelids, and Adjacent hard and soft tissue lost as a result of trauma or surgery. Fabrication of an orbital prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed an orbital prosthesis replacement.	**N**	**N**
D5916	**Ocular prosthesis** Synonymous terminology: artificial eye, glass eye. A prosthesis which artificially replaces an eye missing as a result of trauma, surgery or congenital absence. The prosthesis does not replace missing eyelids or adjacent skin, mucosa or muscle. Ocular prostheses require semi-annual or annual cleaning and polishing. Also, occasional revisions to re-adapt the prosthesis to the tissue bed may be necessary. Glass eyes are rarely made and cannot be re-adapted.	**N**	**N**
D5919	**Facial prosthesis** Synonymous terminology: prosthetic dressing. A removable prosthesis which artificially replaces a portion of the face lost due to surgery, trauma or congenital absence. Flexion of natural tissues may preclude adaptation and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.	**N**	**N**
D5922	**Nasal septal prosthesis** Synonymous terminology: Septal plug, septal button. Removable prosthesis to occlude (obturate) a hole within the nasal septal wall. Adverse chemical degradation in this moist environment may require frequent replacement. Silicone prostheses are occasionally subject to fungal invasion.	**<21**	**Y**
D5923	**Ocular prosthesis, interim** Synonymous terminology: eye shell, shell, ocular conformer, conformer. A temporary replacement generally made of clear acrylic resin for an eye lost due to surgery or trauma. No attempt is made to re-establish esthetics. Fabrication of an interim ocular prosthesis generally implies subsequent fabrication of an esthetic ocular prosthesis.	**<21**	**Y**

		Age Restriction	PA Requirement
D5924	**Cranial prosthesis** Synonymous terminology: Skull plate, cranioplasty prosthesis, cranial impact. A biocompatible, permanently implanted replacement of a portion of the skull bones; an artificial replacement for a portion of the skull bone.	**<21**	**Y**
D5925	**Facial augmentation implant prosthesis** Synonymous terminology: facial implant. An implantable biocompatible material generally onlayed upon an existing bony area beneath the skin tissue to fill in or collectively raise portions of the overlaying facial skin tissues to create acceptable contours. Although some forms of remade surgical implants are commercially available, the facial augmentation is usually custom made for surgical implantation for each individual patient due to the irregular or extensive nature of the facial deficit.	**<21**	**Y**
D5926	**Nasal prosthesis, replacement** Synonymous terminology; replacement nose. An artificial nose produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.	**<21**	**Y**
D5927	**Auricular prosthesis, replacement** Synonymous terminology; replacement ear. An artificial ear produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.	**<21**	**Y**
D5928	**Orbital prosthesis, replacement** A replacement for a previously made orbital prosthesis. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age-related topographical variations.	**<21**	**Y**

		Age Restriction	PA Requirement
D5929	**Facial prosthesis, replacement** A replacement facial prosthesis made from the original mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age-related topographical variations.	**<21**	**Y**
D5931	**Obturator prosthesis, surgical** Synonymous terminology; obturator, surgical stayplate, immediate temporary obturator. A temporary prosthesis inserted during or immediately following surgical or traumatic loss of a portion or all of one or both maxillary bones and contiguous alveolar structures (e.g., gingival tissue, teeth). Frequent revisions of surgical obturators are necessary during the ensuing healing phase (approximately six months). Some dentists prefer to replace many or all teeth removed by the surgical procedure in the surgical obturator, while others do not replace any teeth. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathologic report indicates margins are not free of tumor).	**N**	**N**
D5932	**Obturator prosthesis, definitive** Synonymous terminology: obturator A prosthesis, which artificially replaces part or all of the maxilla and associated teeth, lost due to surgery, trauma or congenital defects. A definitive obturator is made when it is deemed that further tissue changes or recurrence of tumor are unlikely and a more permanent permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.	**N**	**N**
D5933	**Obturator prosthesis, modification** Synonymous terminology: adjustment, denture adjustment, temporary or office reline. Revision or alteration of an existing obturator (surgical,interim, or definitive); possible modifications include relief of the denture base due to tissue compression, augmentation of the seal or peripheral areas to affect adequate sealing or separation between the nasal and oral cavities.	**N**	**N**
D5934	**Mandibular resection prosthesis with guide flange** Synonymous terminology: resection device, resection appliance.. A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with	**N**	**N**

		Age Restriction	PA Requirement
	the maxilla. This allows for some tooth-to-tooth or an improved tooth contact. It may also artifically replace missing teeth and thereby increase masticatory efficiency.		
D5935	**Mandibular resection prosthesis without guide flange** A prosthesis which helps guide the partially rejected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, to assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency. Dentists who treat mandibulectomy patients may prefer to replace some, all or none of the teeth in the defect area. Frequently, the defect's margins preclude even partial replacement. Use of a guide (a mandibular resection prosthesis with a guide flange) may not be possible due to anatomical limitations or poor patient tolerance.	**N**	**N**
D5936	**Obturator prosthesis, interim** Synonymous terminology; immediate postoperative obturator. A prosthesis which is made following completion of the initial healing after a surgical resection of a portion or all of the maxilla; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator which is usually inserted at or immediately following the resection. Generally, an interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis which may replace some or all lost teeth and other lost bone and soft tissue structures. Also, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g. restorations, gingival surgery, etc.) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.	**<21**	**Y**
D5937	**Trismus appliance (not for TMD treatment)** Synonymous terminology: occlusal device for mandibular trismus, dynamic bite opener. A prosthesis which assists the patient in increasing their oral aperture width in order to eat as well as maintain oral hygiene. Several versions and designs are possible, all intending to ease the severe lack of oral opening experienced by many patients immediately following extensive intraoral surgical procedures.	**N**	**Y**

		Age Restriction	PA Requirement
D5951	**Feeding aid** Synonymous terminology: feeding prosthesis. A prosthesis which maintains the right and left maxillary segments of an infant cleft palate patient in their proper orientation until surgery is performed to repair the cleft. It closes the oral-nasal cavity defect, thus enhancing sucking and swallowing. Used on an interim basis, this prosthesis achieves separation of the oral and nasal cavities in infants born with wide clefts necessitating delayed closure. It is eliminated if surgical closure can be affected or, alternatively, with eruption of the deciduous dentition, a pediatric speech aid may be made to facilitate closure of the defect.	**<21**	**N**
D5952	**Speech aid prosthesis, pediatric** Synonymous terminology: nasopharyngeal obturator, speech appliance, obturator, cleft palate appliance, prosthetic speech aid, speech bulb. A temporary or interim prosthesis used to close a defect in the hard and/or soft palate. It may replace tissue lost due to developmental or surgical alterations. It is necessary for the production of intelligible speech. Normal lateral growth of the palatal bones necessitates replacement of this prosthesis occasionally. Intermittent revisions of the obturator section can assist in maintenance of palatalpharyngeal closure (termed a speech aid prosthesis modification). Frequently, such prostheses are not fabricated before the deciduous dentition is fully erupted since clasp retention is often essential.	**<21**	**N**
D5953	**Speech aid prosthesis, adult** Synonymous terminology: prosthetic speech appliance, speech aid, speech bulb. A definitive prosthesis which can improve speech in adult cleft palate patients either by obturating (sealing off) a palatal cleft or fistula, or occasionally by assisting an incompetent soft palate. Both mechanisms are necessary to achieve velopharyngeal competency. Generally, this prosthesis is fabricated when no further growth is anticipated and the objective is to achieve long term use. Hence, more precise materials and techniques are utilized. Occasionally such procedures are accomplished in conjunction with precision attachments in crown work undertaken on some or all maxillary teeth to achieve improved esthetics.	**N**	**N**

D5954 **Palatal augmentation prosthesis** **N** **N**

Synonymous terminology: superimposed prosthesis, maxillary glossectomy prosthesis, maxillary speech prosthesis, palatal drop prosthesis.

A removable prosthesis which alters the hard and/or soft palate's topographical form adjacent to the tongue.

D5955 **Palatal lift prosthesis, definitive** **N** **N**

A prosthesis which elevates the soft palate superiorly and aids in restoration of soft palate functions which may be lost due to an acquired, congenital or developmental defect.

A definitive palatal lift is usually made for patients whose experience with a interim palatal lift has been successful, especially if surgical alterations are deemed unwarranted.

D5958 **Palatal life prosthesis, interim** **<21** **Y**

Synonymous terminology: diagnostic palatal lift.

A prosthesis which elevates and assists in restoring soft palate function which may be lost due to clefting, surgery, trauma or unknown paralysis. It is intended for interim use to determine its usefulness in achieving palatalpharyngeal competency or enhance swallowing reflexes.

This prosthesis is intended for interim use as a diagnostic aid to assess the level of possible improvement in speech intelligibility. Some clinicians believe use of a palatal lift on an interim basis may stimulate an otherwise flaccid soft palate to increase functional activity, subsequently lessening its need.

D5959 **Palatal lift prosthesis, modification** **<21** **Y**

Synonymous terminology: revision of lift, adjustment.

Alterations in the adaptation, contour, form or function of an existing palatal lift necessitated due to tissue impingement, lack of function, poor clasp adaptation or the like.

D5960 **Speech aid prosthesis, modification** **N** **Y**

Synonymous terminology: adjustment, repair, revision.

Any revision of a pediatric or adult speech aid not necessitating its replacement.

Frequently, revisions of the obturating section of any speech aid is required to facilitate enhanced speech intelligibility. Such revisions or repairs do not require complete remaking of the prosthesis, thus extending its longevity.

		Age Restriction	PA Requirement
D5982	**Surgical stent** Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissues to facilitate healing and prevent cicatrization or collapse, a surgical stent may be required in surgical and post-surgical revisions to achieve close approximation of tissues. Usually such materials as temporary or interim soft denture liners, gutta percha, or dental modeling impression compound may be used.	**<21**	**Y**
D5983	**Radiation carrier** Synonymous terminology: radiotherapy prosthesis, carrier prosthesis, radiation applicator, radium carrier, intracavity carrier, intracavity applicator. A device used to administer radiation to confined areas by means of capsules, beads or needles of radiation emitting materials such as radium or cesium. Its function is to hold the radiation source securely in the same location during the entire period of treatment. Radiation oncologists occasionally request these devices to achieve close approximation and controlled application of radiation to a tumor deemed amiable to eradication.	**N**	**N**
D5984	**Radiation shield** Synonymous terminology: radiation stent, tongue protector, lead shield. An intraoral prosthesis designed to shield adjacent tissues from radiation during radiation treatment of malignant lesions of the head and neck region.	**N**	**N**
D5985	**Radiation cone locator** Synonymous terminology: docking device, cone locator. A prosthesis utilized to direct and reduplicate the path of radiation to an oral tumor during a split course of irradiation.	**N**	**N**
D5986	**Fluoride gel carrier** Synonymous terminology: fluoride applicator. A prosthesis which covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.	**N**	**N**
D5987	**Commissure splint** Synonymous terminology: lip splint. A device placed between the lips which assists in achieving increased opening between the lips. Use of such devices enhances opening where	**<21**	**Y**

surgical, chemical or electrical alterations of the lips have resulted in severe restriction or contractures.

		Age Restriction	PA Requirement
D5988	**Surgical splint** Synonymous terminology: Gunning splint, modified Gunning splint, labiolingual splint, fenestrated splint, Kingsley splint, cast metal splint. Splints are designed to utilize existing teeth and/or alveolar processes as points of anchorage to assist in stabilization and immobilization of broken bones during healing. They are used to re-establish, as much as possible, normal occlusal relationships, during the process of immobilization. Frequently, existing prostheses (e.g., a patient's complete dentures) can be modified to serve as surgical splints. Frequently, surgical splints have arch bars added to facilitate intermaxillary fixation. Rubber elastics may be used to assist in this process. Circummandibular eyelet hooks can be utilized for enhanced stabilization with wiring to adjacent bone.	**<21**	**Y**
D5999	**Unspecified maxillofacial prosthesis, by report** Used for procedure which is not adequately described by a code. Describe procedure and submit appropriate documentation.	**N**	**Y**

IMPLANT SERVICES

Implants are not a covered service.

FIXED PROSTHODONTICS

**** Local anesthesia is considered to be part of Fixed Prosthodontic procedures.***

Permanent bridges will be approved for anterior permanent teeth only. Recipients must be 16 to 20 years of age. X-rays must be submitted. Permanent bridges will be approved for a maximum of four (4) units. If greater than four units, a partial denture will be approved, if requested. If anterior and posterior teeth are missing, a partial denture will be approved.

Prosthodontics, fixed - each abutment and each pontic constitutes a unit in a fixed partial denture.

The words "bridge" and "bridgework" have been replaced by the statement "fixed partial denture" throughout this section.

"Classification of Metals - The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content: **high noble** - Gold (Au), Palladium (Pd), and/or Platinum (Pt)≥60% (with at least 40% Au); **noble** - Gold (Au), Palladium (Pd), and/or Platinum (Pt) ≥25%; **predominantly base** - Gold (Au), Palladium (Pd), and/or Platinum (Pt)< 25%.

FIXED PARTIAL DENTURE PONTICS		Age Restriction	PA Requirement
D6210	**pontic - cast high noble metal**	**<21**	**N**
D6211	**pontic - cast predominantly base metal**	**<21**	**N**
D6212	**pontic - cast noble metal**	**<21**	**N**
D6240	**pontic - porcelain fused to high noble metal**	**<21**	**N**
D6241	**pontic - porcelain fused to predominantly base metal**	**<21**	**N**
D6242	**pontic - porcelain fused to noble metal**	**<21**	**N**
D6250	**pontic - resin with high noble metal**	**<21**	**N**
D6251	**pontic - resin with predominantly base metal**	**<21**	**N**
D6252	**pontic - resin with noble metal**	**<21**	**N**

		Age Restriction	PA Requirement
FIXED PARTIAL DENTURE RETAINERS - CROWNS			
D6720	**crown - resin with high noble metal**	**<21**	**N**
D6721	**crown - resin with predominantly base metal**	**<21**	**N**
D6722	**crown - resin with noble metal**	**<21**	**N**
D6750	**crown - porcelain fused to high noble metal**	**<21**	**N**
D6751	**crown - porcelain fused to predominantly base metal**	**<21**	**N**
D6752	**crown - porcelain fused to noble metal**	**<21**	**N**
D6780	**crown - 3/4 cast high noble metal**	**<21**	**N**
D6790	**crown - full cast high noble metal**	**<21**	**N**
D6791	**crown - full cast predominantly base metal**	**<21**	**N**
D6792	**crown - full cast noble metal**	**<21**	**N**
OTHER FIXED PARTIAL DENTURE SERVICES			
D6999	**unspecified, fixed prosthodontic procedure, by report**	**N**	**Y**

ORAL SURGERY SERVICES

Tooth replantation (D7270) is allowed only in cases of traumatic avulsion of a permanent anterior tooth where there are good indications of success.

A biopsy (D7285 & D7286) will only be allowed with verification of the presence of inflammation, interference with dental function, or suspicion of a malignancy.

Skin grafts (D7920) are not allowed in conjunction with a vestibuloplasty.

For recipients 21 years of age and older, procedures D7950 and D7955 are only allowed for reconstruction secondary to tumor surgery.

For recipients 21 years of age and older, excision of hyperplastic tissue (D7970) is only allowed when the condition was caused by denture irritation.

The fee for all oral surgical procedures is inclusive of all examinations and diagnostics, with the following exceptions:

1. One panoramic film will be allowed for patients presenting with bilateral problems and no panoramic film is available.

2. One panoramic film will be allowed if the patient is presenting with bilateral impacted third molars.

2. One panoramic film will be allowed if the radiographs from the referring dentist are not of diagnostic quality. A copy of the film must be sent to the primary care dentist.

4. One panoramic film will be allowed if the patient is a self-referral with no primary care dentist.

** ***Extractions are limited to once per tooth per recipient's lifetime.***

Oral surgical procedures that can be provided by dental surgeons within the scope of their licensure will be considered on a PA basis for individuals under age 21. Payment will be made in accordance with the Medical Assistance Surgical Fee Schedule,

Allowance for surgical assistance is restricted to services by dentists and physicians. Surgical assistance will be allowed only when the assistant's services qualify as a dental or medical necessity. Only one surgical assistant will be allowed. Primary surgeons, assistant surgeons, and anesthesiologists must bill separately for their services. Oral surgical assistance will be allowed in the same manner as physician surgical assistance.

		Age Restricton	PA Requirement
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
D7111	**Coronal remnants – primary teeth** Includes soft tissue-retained coronal remnants	**N**	**N**
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)** Includes routine removal of tooth structure and closure, as necessary	**N**	**N**
SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Includes cutting of gingiva and bone, removal of tooth structure, and closure.	**N**	**N**
D7220	**Removal of impacted tooth - soft tissue** Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	**N**	**N**
D7230	**Removal of impacted tooth - partially bony** Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	**N**	**N**
D7240	**Removal of impacted tooth - completely bony** Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	**N**	**N**
D7241	**Removal of impacted tooth - completely bony, with unusual surgical complications** Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	**N**	**N**
D7250	**Surgical removal of residual tooth roots (cutting procedure)** Includes cutting of gingiva and bone, removal of tooth structure, and closure.	**N**	**N**
OTHER SURGICAL PROCEDURES			
D7260	**Oroantral fistula closure** Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.	**N**	**N**
D7270	**Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus** Includes splinting and/or stabilization.	**⟨21**	**N**

		Age Restriction	PA Requirement
D7280	**Surgical exposure of unerupted tooth** An incision is made and the tissue is reflected and bone removed as necessary to expose the crown This procedure may include but is not limited to situations whereby an attachment is placed to facilitate eruption.	**⟨21**	**N**
D7281	**Surgical exposure of impacted or unerupted tooth to aid eruption** Dense fibrous tissue overlying an impacted or unerupted tooth is reflected and any overlying bone is removed. This procedure may also be performed in conjunction with a separate soft tissue graft procedure.	**⟨21**	**N**
D7285	**Biopsy of oral tissue - hard (bone, tooth)** For surgical removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular curettage.	**N**	**N**
D7286	**Biopsy of oral tissue - soft (all others)** For surgical removal of specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage. For surgical oral pathology procedures, See D0502.	**N**	**N**
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES			
D7310	**Alveoplasty in conjunction with extractions – per quadrant** Usually in preparation for a prosthesis.	**N**	**N**
D7320	**Alveoloplasty not in conjunction with extractions - per quadrant** No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoplasty.	**N**	**N**
VESTIBULOPLASTY			
D7340	**vestibuloplasty - ridge extension (secondary epithelialization)**	**N**	**Y**
D7350	**vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).**	**N**	**Y**
SURGICAL EXCISION OF SOFT TISSUE LESIONS			
D7410	**excision of benign lesion diameter up to 1.25 cm**	**N**	**N**
D7411	**excision of benign lesion diameter greater than 1.25 cm**	**N**	**N**

		Age Restriction	PA Requirement
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS			
D7440	**Excision of malignant tumor - lesion diameter up to 1.25 cm**	**N**	**N**
D7441	**Excision of malignant tumor - lesion diameter greater than 1.25 cm**	**N**	**N**
D7450	**Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm**	**N**	**N**
D7451	**Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm**	**N**	**N**
D7460	**Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm**	**N**	**N**
D7461	**Removal of nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm**	**N**	**N**
EXCISION OF BONE TISSUE			
D7471	**Removal of lateral exostosis –(maxilla or mandible)**	**N**	**Y**
D7490	**Radical resection of mandible with bone graft** Partial resection of mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.	**N**	**N**
SURGICAL INCISION			
D7510	**Incision and drainage of abscess - intraoral soft tissue** Involves incision through mucosa, including periodontal origins.	**N**	**N**
D7520	**Incision and drainage of abscess - extraoral soft tissue** Involves incision through skin.	**N**	**N**
D7530	**Removal of foreign body from mucosa , skin, or subcutaneous alveolar tissue**	**N**	**N**
D7540	**Removal of reaction-producing foreign bodies- musculoskeletal system** May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.	**N**	**N**
D7550	**Partial ostectomy/sequestrectomy for removal of non-vital bone** Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.	**N**	**N**
D7560	**Maxillary sinusotomy for removal of tooth fragment or foreign body**	**N**	**N**

		Age Restriction	PA Requirement
TREATMENT OF FRACTURES – SIMPLE			
D7610	**Maxilla - open reduction (teeth immobilized, if present)** Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.	**N**	**N**
D7620	**Maxilla - closed reduction (teeth immobilized, if present)** No incision required to reduce fracture. See D7610 if interosseous fixation is applied.	**N**	**N**
D7630	**Mandible - open reduction (teeth immobilized, if present)** Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required to reduce fracture.	**N**	**N**
D7640	**Mandible - closed reduction (teeth immobilized, if present)** No incision required to reduce fracture. See D7630 if interosseous fixation is applied.	**N**	**N**
D7650	**Malar and/or zygomatic arch - open reduction**	**N**	**N**
D7660	**Malar and/or zygomatic arch - closed reduction**	**N**	**N**
D7670	**Alveolus –closed reduction, may include stabilization of teeth** Teeth may be wired, banded or splinted together to prevent movement.	**N**	**N**
D7680	**Facial bones - complicated reduction with fixation and multiple surgical approaches** Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.	**N**	**N**
TREATMENT OF FRACTURES - COMPOUND			
D7710	**Maxilla - open reduction** Surgical incision required to reduce fracture	**N**	**N**
D7720	**Maxilla - closed**	**N**	**N**
D7730	**Mandible - open reduction** Surgical incision required to reduce fracture	**N**	**N**
D7740	**Mandible - closed reduction**	**N**	**N**
D7750	**Malar and/or zygomatic arch - open reduction** Surgical incision required to reduce fracture	**N**	**N**
D7760	**Malar and/or zygomatic arch - closed reduction**	**N**	**N**
D7770	**Alveolus - open reduction stabilization of teeth** Fractured bone(s) are exposed to mouth or outside the face; see D7670. Surgical incision required to reduce fracture	**N**	**N**

		Age Restriction	PA Requirement
D7780	**Facial bones - complicated reduction with fixation and multiple surgical approaches** Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.	**N**	**Y**

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

Procedures which are an integral part of a primary procedure should not be reported separately.

D7810	**Open reduction of dislocation** Access to TMJ via surgical opening.	**N**	**N**
D7820	**Closed reduction of dislocation** Joint manipulated into place; no surgical exposure	**N**	**N**
D7830	**Manipulation under anesthesia** Usually done via general anesthesia or intravenous sedation.	**N**	**N**
D7840	**Condylectomy** Surgical removal of all or portion of the mandibular condyle (separate procedure).	**<21**	**N**
D7850	**Surgical discectomy, with/without implant** Excision of the intra-articular disc of a joint	**<21**	**N**
D7852	**Disc repair** Repositioning and/or sculpting of disc; repair of perforated posterior attachment	**<21**	**Y**
D7854	**Synovectomy** Excision of a portion or all of the synovial membrane of a joint	**<21**	**Y**
D7856	**Myotomy** Cutting of muscle for therapeutic purposes (separate procedure).	**<21**	**Y**
D7858	**Joint reconstruction** Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.	**<21**	**Y**
D7860	**Arthrotomy** Cutting into joint (separate procedure).	**<21**	**N**
D7865	**Arthroplasty** Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).	**<21**	**Y**
D7870	**Arthrocentesis** Withdrawal of fluid from a joint space by aspiration.	**<21**	**N**

		Age Restriction	PA Requirement
D7872	**Arthroscopy - diagnosis, with or without biopsy**	**<21**	**Y**
D7873	**Arthroscopy – surgical: lavage and lysis of adhesions** Removal of adhesions using the arthroscope and lavage of the joint cavities.	**<21**	**Y**
D7874	**Arthroscopy – surgical: disc repositioning and stabilization** Repositioning and stabilization of disc using arthroscopic techniques.	**<21**	**Y**
D7875	**Arthroscopy – surgical: synovectomy** Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.	**<21**	**Y**
D7876	**Arthroscopy – surgical: discectomy** Removal of disc and remodeled posterior attachment via the arthroscope.	**<21**	**Y**
D7877	**Arthroscopy – surgical: debridement** Removal of pathologic hard and/or soft tissue using the arthroscope.	**<21**	**Y**
D7880	**Occlusal orthotic device, by report** Presently includes splints provided for treatment of temporomandibular joint dysfunction	**<21**	**Y**
D7899	**Unspecified TMD therapy, by report** Used for procedure which is not adequately described by a code. Describe procedure.	**<21**	**Y**

REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions.

		Age Restriction	PA Requirement
D7910	**Suture of recent small wounds up to 5 cm**	**N**	**N**

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)

Excludes closure of surgical incisions.

D7911	**Complicated suture - up to 5 cm**	**N**	**N**
D7912	**Complicated suture - greater than 5 cm**	**N**	**N**

OTHER REPAIR PROCEDURES

D7920	**Skin graft (identify defect covered, location and type of graft)**	**N**	**N**
D7940	**Osteoplasty - for orthognathic deformities** Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.	**<21**	**N**

		Age Restriction	PA Requirement
D7941	**Osteotomy –mandibular rami**	**<21**	**N**
D7943	**Osteotomy – mandibular rami with bone graft; includes obtaining the graft**	**<21**	**N**
D7944	**Osteotomy - segmented or subapical - per sextant or quadrant**	**<21**	**N**
D7945	**Osteotomy - body of mandible** Surgical section of the lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.	**<21**	**N**
D7946	**LeFort I (maxilla - total)** Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	**<21**	**N**
D7947	**LeFort I (maxilla - segmented)** When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report."	**<21**	**N**
D7948	**LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft** Surgical section of upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	**<21**	**N**
D7949	**LeFort II or LeFort III - with bone graft** Includes obtaining autografts.	**⟨21**	**N**
D7950	**Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report** Includes obtaining autograft and/or allograft material. Ridge augmentation/sinus lift procedure.	**N**	**N**
D7955	**Repair of maxillofacial soft and hard tissue defect** Various soft tissue grafting procedures may be used alone or in combination with autograft, allograft, or alloplastic materials to augment or repair the defect and restore anatomic structure to required form and function. These procedures may require multiple surgical approaches.	**N**	**N**
D7960	**Frenulectomy (frenectomy or frenotomy) - separate procedure** The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	**N**	**N**
D7970	**Excision of hyperplastic tissue - per arch**	**N**	**N**

		Age Restriction	PA Requirement
D7971	**Excision of pericoronal gingiva** Surgical removal of inflammatory of hypertrophied tissues surrounding partially erupted/impacted teeth.	**<21**	**N**
D7980	**Sialolithotomy** Surgical procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.	**N**	**N**
D7981	**Excision of salivary gland, by report**	**N**	**N**
D7982	**Sialodochoplasty** Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.	**<21**	**Y**
D7983	**Closure of salivary fistula** Surgical closure of an opening between a salivary duct and/or gland and the cutaneous surface, or an opening into the oral cavity through other than the normal anatomic pathway.	**<21**	**Y**
D7990	**Emergency tracheotomy** Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.	**N**	**N**

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
DENTAL SERVICES

HANDICAPPING LABIOLINGUAL DEVIATION (HLD) INDEX – (RI-Mod)
Orthodontic Diagnostic Score Sheet

Date of Review _____

Client Name: _____ Client Medicaid Number: _____
Client Birthdate: _____
Provider Name: _____ Provider Medicaid Number: _____
Provider Address: _____Phone Number: _____

State of Dentition: _____ Primary _____Transitional _____ Permanent

PART A. PROCEDURE:

Note: 1 – 6 - If any one of these conditions exist, indicate an ***"X"*** *and score no further.*

1. Deep impinging overbite when lower incisors are destroying the soft tissue of the palate. _____
2. Crossbite of three or more permanent and/or deciduous posterior teeth or anterior crossbite of one to two individual teeth when destruction of soft tissue is present. _____
3. Congenital birth defect (e.g. cleft palate) or deviations that affect skeletal relationship and/or dentition. _____
4. Impacted permanent teeth with most of the permanent dentition present (excluding third molars). _____
5. Overjet greater than 6 mm with incompetent lips or reverse overjet. _____
6. Malocclusion with openbite from canine to canine.

PART B. PROCEDURE:

Complete 7. - 10. if case <u>does not</u> qualify in 1 – 6 above. The total score in Part B. will determine if the case qualifies for orthodontic treatment. *A score of 20 or more qualifies for authorization****. Completion instructions are attached.***

- Position the patient's teeth in centric occlusion. Record measurements in the order given and round to the nearest millimeter (mm).
- Enter Score "0" if condition is absent.
- Note: **If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score <u>only the most severe condition</u>. Do not score both conditions.**

	CONDITIONS	HLD SCORE
7.	Overjet in mm. (1 – 5 mm)	_____
8.	Overbite in mm.	_____
9.	Ectopic eruption, other than anterior teeth. Count each tooth excluding 3rd molar(s) (Score= # of teeth x 3) List teeth: _____	_____
10.	Anterior crowding: Score one point for MAXILLA, and/or one point for MANDIBLE: (Two point maximum for anterior crowding) (Score x 5 = _____)	_____
	(PART B.) TOTAL SCORE	_____
	Reviewing Consultant	_____

Handicapping Labiolingual Index (HLD) (RI-Mod)
Scoring Instructions for Severe Malocclusions

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. The absence of any condition must be recorded by entering "0" on numbers 7 - 10. Measurements are rounded to the nearest millimeter.

PART A.

1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.

PART B.

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. *(Enter the number of millimeters as the HLD score).*

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. "Reverse" overbite may exist in certain conditions and should be measured and recorded. *(Enter the number of millimeters as the HLD score).*

9. Ectopic Eruption: Count each tooth. Teeth deemed to be ectopic must be blocked out of and clearly out of alignment in dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #10, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter the number of teeth on the score-sheet and multiply by three (3). *Enter the multiplied total as the HLD score*.

10. Anterior Crowding: Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #9, ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter a score of ***one*** if crowding is present in the maxillary arch and a score of ***one*** if crowding is present in the mandibular arch. There is a ***two point*** maximum for anterior crowding. Multiply this score by five (5). *Enter the multiplied total as the HLD score*.

ORTHODONTIC SERVICES

Orthodontics are limited to medically necessary services in order to correct handicapping malocclusion in recipients under age 21.

Handicapping Malocclusion

An occlusion that has an adverse effect on the quality of a person's life that could include speech, function or esthetics that could have sociocultural consequences. Examples would be significant discrepancies in the relationships of the jaws and teeth in anteroposterior, vertical or transverse directions.

Medically Necessary

When a situation exists that could have a detrimental effect on the structures that support the teeth, and if damaged sufficiently, could lead to the loss of function.

Allowance may continue for orthodontic services on recipients losing EPSDT eligibility (reaching their 21st birthday) under the following circumstances:

1. Eligibility for Medical Assistance is maintained;

2. The request for prior authorization is approved and the work is initiated *prior to* the recipient's 21st birthday.

Prior Authorization Requests

All requests for prior authorization of payment must include the diagnosis, length, and type of treatment. Records, which include diagnostic casts (study models), cephalometric film, panoramic film or a complete series of intraoral radiographs, and diagnostic photographs must be submitted for full orthodontic treatment review.

Orthodontic treatment will be approved only where there is evidence of a favorable prognosis and a high probability of patient compliance in completing the treatment program.

Payment for Orthodontic Records

If an orthodontic case ***is not*** approved for payment, Medical Assistance will pay the orthodontist a fee for examination and records. Procedure Code D8660. *This is limited to once every two (2) years*. These codes are tied to each distinct Prior Authorization (PA) request for full orthodontic treatment. If a request is received and denied as not medically necessary at that time, an allowance would not be made. If a subsequent request is received and approved because of changes in the child's mouth, an allowance would be made in that instance.

If an orthodontist sees a patient for an examination only, and the patient does not proceed with diagnostic records, Medical Assistance will pay for a Comprehensive Oral Evaluation.

Post-treatment maintenance retainers will not be replaced if lost or damaged.

ORTHODONTIC SERVICES

Claims Coding and Reimbursement

Orthodontics are medically necessary services needed to correct handicapping malocclusion in recipients under age 21. The HDL (RI Mod) Index (Handicapping Labio-lingual Deviation Index) is applied to each individual case by Board qualified orthodontic consultants to identify those cases that clearly demonstrate medical necessity by determining the degree of the handicapping malocclusion. The HDL Index is a tool that has proven to be successful in identifying a large range of very disfiguring malocclusions and two known destructive forms of malocclusion (deep destructive impinging bites and destructive individual anterior crossbite).

DENTITION

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth AND PRIOR to cessation of growth; that would affect orthodontic treatment.

***Adult Dentition*:** The dentition that is present after the cessation of growth that would affect orthodontic treatment.

LIMITED ORTHODONTIC TREATMENT

Orthodontic treatment with a limited objective, not involving the entire dentition. May be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

		Age Restriction	PA Requirement
D8010	**Limited orthodontic treatment of the primary dentition**	**⟨21**	**Y**
D8020	**Limited orthodontic treatment of the transitional dentition**	**⟨21**	**Y**
D8030	**Limited orthodontic treatment of the adolescent dentition**	**⟨21**	**Y**
D8040	**Limited orthodontic treatment of the adult dentition**	**⟨21**	**Y**

INTERCEPTIVE ORTHODONTIC TREATMENT

Orthodontic therapy that reduces or eliminates the severity of an existing malocclusion. It most often involves early correction of vertical, horizontal, or anteroposterior skeletal discrepancies. Included would be such procedures as distalization, protraction, expansion, space maintenance, and in control of harmful oral habits.

D8050	**Interceptive orthodontic treatment of the primary dentition**	**⟨21**	**Y**
D8060	**Interceptive orthodontic treatment of the transitional dentition**	**⟨21**	**Y**
D1515	**Space maintainer, fixed bilateral**	**⟨21**	**N**

COMPREHENSIVE ORTHODONTIC TREATMENT

The coordinated diagnosis and treatment leading to the improvement of a patient's dentofacial deformity or dentoalveolar skeletal discrepancies including anatomical, functional and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patients' needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.
Orthodontic treatment involves the placement of bands or bonded brackets for at least a two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient. Comprehensive treatment ends when the entire adult dentition (except third molars) has been placed in proper occlusion.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When billing for comprehensive orthodontia treatment services, the following codes will be used, as appropriate:

Units	Transitional	Adolescent	Adult	Age Restriction	PA
Procedure code: 1	**D8070**	**D8080**	**D8090**	**<21**	**Y**
	Procedure codes - 1st 6 months				
1 - 6	**D8071**	**D8081**	**D8091**	**<23**	**Y**
	Procedure codes - 2nd 6 months				
1 - 6	**D8072**	**D8082**	**D8092**	**<23**	**Y**
	Procedure codes - 3rd 6 months				
1 - 6	**D8073**	**D8083**	**D8093**	**<23**	**Y**
	Procedure codes - 4th 6 months				
1 - 6	**D8074**	**D8084**	**D8094**	**<23**	**Y**

		Age Restriction	PA Requirement
D8070	**Comprehensive orthodontic treatment of the transitional dentition**	**⟨21**	**Y**
D8080	**Comprehensive orthodontic treatment of the adolescent dentition**	**⟨21**	**Y**
D8090	**Comprehensive orthodontic treatment of the adult dentition**	**⟨21**	**Y**

TREATMENT FOR CORRECTION OF HARMFUL HABITS

D8210	**Removable appliance therapy**	**⟨21**	**Y**
	Includes appliances for thumb sucking and tongue thrusting.		
D8220	**Fixed appliance therapy**	**⟨21**	**Y**
	Includes appliances for thumb sucking and tongue thrusting.		

OTHER ORTHODONTIC SERVICES

D8660	Pre-Orthodontic treatment visit	**⟨21**	**N**
	Payment for orthodontic records when an orthodontic case is not approved.		
D8999	**Unspecified orthodontic procedure, by report**	**⟨21**	**Y**
	Used for procedure, which is not adequately described by a code. Describe procedure and submit appropriate documentation.		

Full course orthodontic treatment usually involves the placement of bands or bonded brackets for a minimum two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley Appliance,

may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When an appliance is provided in conjunction with a full course of treatment, a separate prior authorization request will be required for the provision of the special appliance. Payment will be processed when the special appliance has actually been provided to the patient.

The following codes should be utilized when requesting the appliances listed below:

Restricted to under age 21, require PA, and deemed medically necessary.

D1515	**Orthodontic - Space Maintainer, fixed bilateral**	**⟨21**	**N**
D8020	**Orthodontic -Head Gear Therapy**	**⟨21**	**Y**
D8030	**Orthodontic -Minor Tooth Movement with Hawley Appliance**	**⟨21**	**Y**
D8060	**Orthodontic -Maxillary Expansion Appliance**	**⟨21**	**Y**
D8220	**Orthodontic -Tongue Guard Fixed/Removable**	**⟨21**	**Y**
D8680	**Orthodontic -Tooth Retainer**	**⟨21**	**N**

Requests for payment can only be submitted after placement of permanent bands / wires and completion of six month time intervals.

Orthodontic services and supplies authorized for eligible recipients will be allowed only as long as they remain eligible for the Medical Assistance Program and continue to meet the age limitations.

ADJUNCTIVE GENERAL SERVICES

Anesthesia

General anesthesia is paid for the first 30 minutes (D9220) and each additional 15 minutes (D9221) for up to one hour on the same day of service for services rendered in the office setting. IV sedation is paid per date of service, not by time, and limited to recipients under 21 years of age. Anesthetic Management is limited to one (1) method per patient for the same day of service.

When billing for D9221, indicate the number of units in the Description of Service section of the ADA claim form and **highlight** the section. The billed amount should correspond to the number of units.

Providers are required to submit a copy of their permit to administer anesthesia and/or sedation to Medical Assistance, upon request.

		Age Restriction	PA Requirement
UNCLASSIFIED TREATMENT			
D9110	**Palliative (emergency) treatment of dental pain-minor procedure** This is typically reported on a "per visit" basis for emergency treatment of dental pain.	**N**	**N**
ANESTHESIA			
D9220	**Deep sedation/general anesthesia - first 30 minutes**	**⟨21**	**N**
D9221	**Deep sedation/general anesthesia - each additional 15 minutes**	**⟨21**	**N**
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide**	**⟨21**	**N**
PROFESSIONAL CONSULTATION			
D9310	**Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)** Type of service provided by a dentist or dental specialist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate source. The dentist may initiate diagnostic and/or therapeutic services.	**N**	**N**
PROFESSIONAL VISITS			
D9410	**House call / Extended Care Facility Call** Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report <u>in addition</u> to reporting appropriate procedure codes for actual services performed.	**N**	**N**
D9420	**Hospital call** May be reported when providing treatment in hospital or ambulatory surgicenter, <u>in addition</u> to reporting appropriate codes for actual services performed.	**N**	**N**

		Age Restriction	PA Requirement
DRUGS			
D9610	**Therapeutic drug injection, by report** Includes antibiotics, intravenous, or injection of sedative.	**N**	**Y**
D9630	**Other drugs and/or medicaments, by report** Includes, but not limited to, oral antibiotics, oral analgesics, oral sedatives, and topical fluoride dispensed in the office for home use; does not include writing prescriptions.	**N**	**Y**
MISCELLANEOUS SERVICES			
D9910	**Application of desensitizing medicament** Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.	**⟨21**	**Y**
D9930	**Treatment of complications (post-surgical) - unusual circumstances, by report** For example, treatment of a dry socket following extraction or removal of bony sequestrum.	**N**	**Y**
D9940	**Occlusal guard, by report** Removable dental appliance which is designed to minimize the effects of bruxism (grinding) and other occlusal factors.	**⟨21**	**Y**

SERVICES FOR INDIVIDUALS WITH MENTAL RETARDATION OR OTHER DEVELOPMENTAL DISABILITIES

The services outlined below may be provided to recipients of any age with no prior authorization requirements as long as those recipients have been determined to be developmentally disabled by the Department of Mental Health, Retardation and Hospitals, with the exception of X9920:

X1110	**Adult prophy**
X1204	**Topical application of fluoride (excluding prophylaxis) - adult**
X1351	**Sealant - per tooth**
X4220	**Gingival curettage, surgical, per quadrant, by report**
X4240	**Gingival flap procedure, including root planning - per quadrant**
X4341	**Periodontal scaling and root planning - per quadrant**
X4345	**Periodontal scaling performed in the presence of gingival inflammation**
X4910	**Periodontal maintenance procedures following active therapy**
X4999	**Unspecified periodontal procedure by report - *PA required***
X9220	**General anesthesia - first 30 minutes**
X9221	**General anesthesia - each additional 15 minutes**
X9920	**Behavior Management, Dental** For patients whose medical status and/or behavior requires special management techniques for the safe delivery of necessary oral health services. ***May be reported in addition to treatment provided.***

***** *These local codes will be obsolete once HIPAA compliance is in effect.***